CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE: Certificate of Death

2. Form No. if available:

3. Type—(cards, paper, etc.) Bound Book

4. Dates:

5. Volume accumulated yearly:

6. Size of Record: Misc.

7. Number of copies made: One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center: Micro. Perm.

c. Total: 12 yrs. and Micro. Perm.

10. Equipment and space freed.

11. In your opinion does this record have any historical significance?

YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center: Microfilm Permanent

c. Total: 12 yrs. and Microfilm Permanent

14. Disposal Method

A. ☐ To be sold as scrap or waste paper

B. ☒ To be Burned or shredded

C. ☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Force 3/28/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G30324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

Registered No. G30324

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eagle St
(c) Hospital or institution: Sinai Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Orchard Beach Camp Bay (If outside city or town limits, write RURAL and give town) Maryland
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LeRoy Phelps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	10	hr. min.

9. Birthplace Sinai Balto Gen Hosp (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Leroy Phelps Sr
(b) Address Orchard Beach Glen Burnie Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2 45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Thomas W Bargleton
(b) Address Glen Burnie, Md

19 (a) 7-2-1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

JUL

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1945, to 7/1 1945, and that I last saw him alive on 7/1 1945.

Immediate cause of death: Congenital Heart Malformation — Duration: 9 days

Due to: — Duration: 9 days

Due to: — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cong Heart Malformation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Madison Bloxom III M. D.

Address Sinai Balto Gen Hosp Date signed 7/1 45

VS 150

G30325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G30325 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E. 30th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sarah E. Sanner (SADIE E.)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/68

8. AGE: Years	Months	Days	If less than one day
76	9	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George W. Peasch
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Edwards
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robt. Jefferson
(b) Address 1509 E 35th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Avenue

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt Royal Ave

19 (a) JUL 2 1945 Huntington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1945, to 6/30 1945, and that I last saw her alive on 6/30 1945.

Immediate cause of death Cardiac FAILURE — Duration

Due to SENILITY, OBESITY, STRANGULATED HERNIA, HERNIAPLASTY

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/30/45

Major findings of operation: Strangulated ventral hernia

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul J. Herold M. D.
Address Md. Gen. Hosp. Date signed 6/30/45

X

G30326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D G30329 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N.Port Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 N.Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Hetterich

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A.Hetterich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.7,1871

8. AGE: Years 73 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Adam Hetterich
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs.Mary A.Hetterich
(b) Address 20 N.Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto. Md.

18 (a) Funeral director Philip Hennig Sons
(b) Address 2024 Orleans St.

19 (a) (Date) JUL 2 1945 by (signature) Hennig for Phillip Hennig (b) Address 441 Ellwood Ave. Date signed 7/2/45

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/27 1945 to 6/29 1945
and that I last saw him alive on 6/28 19 45

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Chron. Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lunberg Date signed 7/2/45

VS 190

G30327 ✓ G30327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 Portugal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Portugal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wladkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Ln keg Dump.
11. Industry or business National Brewery

FATHER
12. Name John Wladkowski
13. Birthplace Poland.

MOTHER
14. Maiden Name Adela Borichowski
15. Birthplace Poland

16 (a) Informant Adela Borichowski
(b) Address 1605 Portugal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director William Fialkowski
(b) Address 1618 Eastern Ave

19 (a) (Date received) JUL 2 1945 Registrar Huntington Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to June 29 1945 and that I last saw him alive on June 24 1945

Immediate cause of death	Duration
Acute Valvular Heart disease	
Due to Endocarditis Chronic valvular Heart	1 week
Due to	
Other Conditions Chronic nephritis	1 year

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature John J. Jasper M. D.
Address 2617 Eastern Ave Date signed

929

G30328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G30328 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital. V4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1466 Stevenson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** KATIE RIDGEWAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Harry Ridgeway
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 17 1887

8. AGE: Years	Months	Days	If less than one day
(58)	5	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Chas Gontrum
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mollie Kelly
15. Birthplace England

16 (a) Informant Harry Ridgeway
(b) Address 1466 Stevenson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director Jay. F. Dill
(b) Address 1521 E. Fort Ave.

JUL 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1945 to 6-29 1945 and that I last saw her alive on 6-29 1945.

Immediate cause of death Cardio-resp. failure
Due to Myocardial failure
Due to Uremia
Other Conditions
(Include pregnancy within 3 months of death)

Duration
over

Date of operation
Major findings of operation:
of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Fuchs jr. M.D.
Address Sinai Hosp. Date signed 6/29

VS 180

G30329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G30329 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 S. Kresson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S. Kresson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Karczmarek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Julia Karczmarek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2 1889

8. AGE: Years	Months	Days	If less than one day
56	3	28	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Karczmarek
13. Birthplace Poland

MOTHER
14. Maiden Name Helen Baczkiel
15. Birthplace Poland

16 (a) Informant Mrs. Julia Karczmarek
(b) Address 26 S. Kresson street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 7 (day) 4 (year) 45

(c) Cemetery or crematory St Stanislaus Cem
Location Balto. City

18 (a) Funeral director John M. Weber
(b) Address 40 S. Chester Street

19 (a) JUL 2 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1945 to June 30 1945.
and that I last saw h alive on 6-29-45 1945

Immediate cause of death Cardiac Decompensation
Renal Insufficiency

Duration Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Adam C Eastham M. D.
Address 3139 E. Baltimore St. Date signed 7-2-45

Huntington Williams, M.D.

24 X

G30330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30330 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 93
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Nathan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Morris Goldberg
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Rosie Nathan
(b) Address 2104 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1430 N. Balto. St

19 (a) (Date rec'd by registrar) (b) Huntingtown, Williams Mgr Editor

JUL 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2- 1945 at 4 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 July 2 1945 and that I last saw her alive on July 1 1945

Immediate cause of death: Cerebral Thrombosis — Duration: 12d.
Due to: Hypertension
Due to: Cordis Vascula
Other Conditions: Edema of Lungs — Duration: 2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M D Baylin
Address 2040 Eutaw Date signed 7/2 1945

X

G30331 ✓ G30331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Raynor
(c) Hospital or institution: West Baltimore General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Harrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raoul Foull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county and state)

10. Usual Occupation: Merchant

11. Industry or business: Mess Shop

FATHER
12. Name: Pinching -
13. Birthplace: Russia

MOTHER
14. Maiden Name: Elsie -
15. Birthplace: Russia

16 (a) Informant: Mrs. Alice Foull
(b) Address: 3902 Harrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory: Jonathan Adle
Location:

18 (a) Funeral director: Jos. Heuisler Inc
(b) Address: 1439 E. Balto St.

19 (a) JUL 2 1945 (Date registered) Registrar: Beatrice Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1945 to 7-2 1945 and that I last saw h. alive on 7-2 1945.

Immediate cause of death: Respiratory failure

Due to: Cerebral embolism

Due to: Arteriosclerotic Cardiovascular Elements

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Rudolf Baldauf M.D.
Address: West Baltimore General Hospital Date signed: 7-2-45

VS 150

G30332 ✓ G30332 Cmc

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Gold Spring • Belvedere Ave
(c) Hospital or institution: LEVINDALE MOHE
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Gold Spring • Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HYMAN COHEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 99 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant —
(b) Address —

17 (a) (Burial, cremation or removal) (b) Date thereof July 2/45 (month) (day) (year)

(c) Cemetery or crematory Holy Land Shomrai Shalom
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1709 E. Lexington Wilkens Ave

19 (a) (Date rec'd by registrar) (b) 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 9 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to June 30 1945 and that I last saw h er alive on June 30 1945

Immediate cause of death Bronchopneumonia — Duration

Due to Cerebral Thrombosis

Due to

Other Conditions Spinal cord tumor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Levine M.D.
Address Levindale Date signed 7/20/45

82B

G30333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. G30333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2336 W. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2336 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Edna (Dunn) Grams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~Married, Widowed~~ or divorced: Married

6 (b) Name of husband or wife: Paul V Grams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1908

8. AGE: Years: 36 | Months: 8 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward V Dunn
13. Birthplace Md

MOTHER
14. Maiden Name Julia C McGeric
15. Birthplace Md

16 (a) Informant Mrs Julia Dunn
(b) Address 2336 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balt. Md

18 (a) Funeral director Harry A. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) Date received JUL 2 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 12:23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 1942 to July 1 1945, and that I last saw h[illegible] alive on June 30 1945.

Immediate cause of death: Acute Congestive Heart Failure — Duration: —

Due to: Hypertensive Cardio-vascular-Renal Disease — Duration: 3 yrs +

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operations:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgewood Longer M. D.
Address Bon Secours Hosp Date signed 7/4/45

G30334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30334 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1845 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman E Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Bernadine Breuder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	6	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Edward A. Becker
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Lotz
15. Birthplace Germany

16 (a) Informant Mrs Mary Becker
(b) Address 1845 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A Weitzel
(b) Address 4101 Edmondson Ave

19 (a) JUL 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30-1945, at 5-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28 19 45 to 6-30 19 45, and that I last saw h. alive on 6-30 19 45.

Immediate cause of death Coronary Thrombosis — Duration 1 day
Due to
Due to
Other Conditions Bronchial Asthma — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Bekreiber M. D.
Address 545 Fulton ave Date signed 7-2-45

X

G30335 G30335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bayview - Oakland
(c) Hospital or institution: West Baltimore Gneral Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6915 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Enoch

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-6023

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Julia E
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
75	-	3		

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Retired Letter Carrier

11. Industry or business U S Post Office

FATHER 12. Name Benjiman F Enoch

13. Birthplace Md

MOTHER 14. Maiden Name Emily J Joyce

15. Birthplace and reside Md

16 (a) Informant Margaret E Poorbaugh

(b) Address 6915 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 - 1945 (month) (day) (year)

(c) Cemetery or crematory London Pk

Location Baltimore Md

18 (a) Funeral director Frank H Leak

(b) Address 914-34 36 St

19 JUL 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945 to June 30 1945, and that I last saw him alive on June 30 1945.

Immediate cause of death Respiratory failure

Due to Carcinoma of urinary bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Biedermann M.D.

Address W Balto Gellman Gneral Date signed 7/1/45

G30336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30336 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANKS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D O A
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Burgundy St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME URBAN BIRKLEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife EMMA BIRKLEIN

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MAY. 25. 1863

8. AGE: Years	Months	Days	If less than one day
82	12	6	hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace NOT KNOWN

16 (a) Informant EMMA BIRKLEIN
(b) Address 913 BURGUNDY. ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM
Location EASTERN AVE ROAD

18 (a) Funeral director Bernard C Hanke
(b) Address 121 E West St

19 (a) JUL 2 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1 1945 at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fredericks M.D. Medical Examiner.
Date signed 7/2/45

G30337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G30337 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 N. Bradford St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Bradford Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie J. Prochaska

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	17	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Barbara Dayberry-daughter
(b) Address 825 N. Bradford Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

JUL 2 - 1945 Huntington Hilliard
(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 45 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945 to 6-30 1945 and that I last saw h— alive on 6-30 1945.

Immediate cause of death	Duration
aortic incompetency	3 days
Due to Cardio. Vascular Disease	unknown
Due to	
Other Conditions Bronchial asthma	unknown

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — — —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Dewe M. D.
Address 7 E. Mon. St Date signed 7-2-45

VS 150

G30338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1639

G30338 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME - Frances Romanna (Fannie) B. Storke

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wilbur Thomas Storke
6 (c) If alive, give age years

7 Birth date of deceased (mo., day, yr.) April 3, 1898

8. AGE: Years	Months	Days	If less than one day
47	2	27	hr. min.

9 Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Zinser
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Ruley
15. Birthplace Baltimore, Md.

16 (a) Informant Husband
(b) Address 3323 McElderry Street

17 (a) Burial (b) Date thereof 7/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3310 Taylor Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date received by registrar) (b) Wilson Williamsville

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 1.2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bi Chloride of Mercury Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 29 1945 9:30 P.M.
(b) Where did injury occur? 3323 Mc Elderry St.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Bichloride of Hg. Ch. Tablets

23. Signature Holmes P. Wheeler M.D.
Medical Examiner.
Date signed 6-30-45

X

G30339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 Wilkens Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reinhardt Lorenz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Living

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/4/1862

8. AGE: Years 82 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Joseph Lorenz
13. Birthplace Germany

MOTHER 14. Maiden Name Wilkens
15. Birthplace Germany

16 (a) Informant Marie E. Waltenhofer
(b) Address 2645 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral City
Location

18 (a) Funeral director Ruth & B.M. Walter
(b) Address Pratt & Stricker Sts

19 (a) 7-3-1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Acute Pulmonary Edema
Hypertrophy & acute dilation of Heart

Other Conditions Fractured leg bones

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following: 20-5

(a) Date of injury June 29, 1945 M.
(b) Where did injury occur? Wilkens Ave & Milling Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto (Pedestrian)

23. Signature Howard J. Waddell M.D. (Medical Examiner.)

Date signed 6-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

G30340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G30340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percy Driver

3 (b) If veteran, name war

3 (c) Social Security Account No:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45 yrs.			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Edward Driver
13. Birthplace Md.

MOTHER
14. Maiden Name Lillie
15. Birthplace Md

16 (a) Informant Edward Driver
(b) Address 505 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Elroy Outlaw
(b) Address 1000 Brant Ave

19 (a) Date received by local registrar JUL 2 1945 (b) Signature of Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed June 25 1945

G30341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

G30341
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Russell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Randolph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1930

8. AGE: Years	Months	Days	If less than one day
15			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Charles Randolph
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Marie Randolph
15. Birthplace Md

16 (a) Informant Charles Randolph
(b) Address 1220 Russell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elroy O. Wilson

18 (a) Funeral director 10000 Brantly Ave
(b) Address

19 (a) Date received (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1945, at 4:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25-3

(a) Date of injury 6/27/45 at 3 P. M.
(b) Where did injury occur? Spring Garden, Westport, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning

23. Signature Robert Ed Graham M.D. Medical Examiner.
Date signed June 28 1945

X

G30:342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30:342

Registered No. 2 4864

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: North Broadway
(c) Hospital or institution: Church Home + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 33 days
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: (If outside city or town limits, write RURAL and give town)
(d) Street No.: 315 Rossiter Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Harriette Kearfott

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: John Kearfott
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 14 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	8	17		

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Chief of Hospital Welfare
11. Industry or business:

FATHER
12. Name: John W. Stewart
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Emma A. Wilson
15. Birthplace: Maryland

16 (a) Informant: Mr. John R. Kearfott
(b) Address: 315 Rossiter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-5-45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location:

18 (a) Funeral director: [illegible]
(b) Address: 5305 Reisterstown Rd

19 (a) Filed: JUL 2 1945 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945, at 6 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1945, to July 1 1945 and that I last saw her alive on June 30 1945

Immediate cause of death	Duration
Pulmonary embolus	
Due to phlebitis in left leg	
Due to generalized arteriosclerosis	
Other Conditions: diabetes	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Phyllis R. Clayton M.D.
Address: Church Home + Hosp. Date signed 7/1/45

VS 150

X J. N. Pram

G30343 — BALTIMORE CITY HEALTH DEPARTMENT — G30343 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenmount Ave. 49th Sheep
(c) Hospital or institution: The Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Ave. Route #5 Box 91 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS RUCKER STRAUSS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	M	W	Married

6 (b) Name of husband or wife: Eva M. Strauss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 14, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	15	hr. min.

9. Birthplace: A. A. Co., Maryland (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business: Childrens Hosp.

FATHER
12. Name: John Strauss
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Jones
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mrs. Eva M. Strauss
(b) Address: Montgomery Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive Cem. Co.
Location: Randallstown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by Registrar: JUL 2 - 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/45 19 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 6/29/45

G30344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida M. Powell

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lloyd D. Powell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1870

8. AGE: Years 75 76 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry C. Voight
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Gross
15. Birthplace Germany

16 (a) Informant Miss Lillie M. Voight
(b) Address 2505 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (Signature of Registrar) Huntington for Williams, M.D. Registrar

JUL 2 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945 at 8 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Burst bronc.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 6/27/45 at 6:45 P.M.
(b) Where did injury occur? Belvedere Ave. Fall
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Fell off street car

23. Signature Thomas J. Williams M.D.
Medical Examiner.
Date signed 7-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30345

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 Yale Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Yale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET R. WALLACE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George W. Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	5	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward F. Lohman
13. Birthplace Germany

MOTHER
14. Maiden Name Fredricka Nolte
15. Birthplace Frederick, Md.

16 (a) Informant Mr. George W. Wallace
(b) Address 423 Yale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

7-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to June 29 1945; and that I last saw h[illegible] alive on June 15 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 weeks
Due to Arteria Sclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. A. Billups M. D.
Address 2224 N. North Ave. Date signed July 3/45

VSR 180

G30346

G30346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Hillsdale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. GUARINO

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph Guarino

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1871

8. AGE: Years 74 | Months 2 | Days 3 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Alphonso Alfano
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Peter A. Guarino
(b) Address 3704 Hillsdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945 to June 30 1945 and that I last saw h[illegible] alive on June 29 1945.

	Duration
Immediate cause of death Acidosis	
Diabetic Gangrene of Left toes	7 wks
Due to Diabetic Mellitus.	28 yrs
Due to	
Other Conditions Hypertension Heart Exhaustion	10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Keown M.D.
Address 1938 Linden Ave Date signed 7/2/45

VS 150

G30347 G30347

AB-94271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1467

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1560 Carswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN F. EYRING

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Rosa Spane
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 6- 1864
8. AGE: Years 81 | Months 3 | Days 25 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Baltimore School System

FATHER
12. Name Adolph Eyring
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received 1945 (Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1- 1945, at 4.45AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1945 to 7-1 1945 and that I last saw h- im alive on 7-1- 1945.

Immediate cause of death: Acute heart failure — Duration
Due to: Arterio-sclerosis
Due to:
Other Conditions: Cardiac Edema & Metastasis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Cutler M. D.
Address City Hospitals Date signed 7-1-45

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G30348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 808

G30348 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Lyndhurst St
(c) Hospital or institution: Seton Balt. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 Ashalnd Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret or Maggie Mcnellis GIBARDI

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband xxxxx late Carmine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10 1881

8. AGE: Years 64 | Months 2 | Days 9 | If less than one day hr min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

MOTHER — FATHER

12. Name De Filippo-PASQUALE

13. Birthplace Italy

14. Maiden Name VINCENZA CONTI

15. Birthplace Italy

16 (a) Informant Paul P. Girardi SON

(b) Address 722 N. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3rd45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Fiquell Wells, Inc.

(b) Address 52 N. Morley St.

19 (a) (Date rec'd by reg.) JUL 2-1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23 1945 to 6/29 1945 and that I last saw her alive on 6/29 1945.

Immediate cause of death: Encephalitis — Duration: 1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John McAlister Blackwell M. D.
Address S. B. G. Hosp. Date signed 6/29/1945

G30349

TH. 12068

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G30349

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16- 9-15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 Belleview Ave (If rural give location)
(e) Citizen of foreign country? Between (Yes or No) If yes, name country

3 (a) FULL NAME John Schulze

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1st 1867

8. AGE: Years	Months	Days	If less than one day
78	4	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carston Schulze
13. Birthplace Germany

MOTHER
14. Maiden Name Ellen ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 3 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director Byrnes Funeral Home
(b) Address 363 Falls Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945 19 , at 1:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-28 19 , to 7-1-45 19 , and that I last saw him alive on July 1st 19 45 .

Immediate cause of death	Duration
Bronchopneumonia	5 Days
Due to Organic valvular	
Due to	
Other Conditions Generalized Arteriosclerosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7-2-45

VS 1M

X

G30350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G30350

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Ind. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Unionville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Samuel Forney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dennie B. Forney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1877

8. AGE: Years 68 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Frederick Co. Md
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Jesse Samuel Forney
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Lindsay
15. Birthplace Md

16 (a) Informant Eva Puddester
(b) Address 4716 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)

(c) Cemetery or crematory Linganore
Location Unionville, Fred Co. Md

18 (a) Funeral director C. M. Wantz
(b) Address Winfield Md

19 (a) (Date rec'd) Registrar

JUL 9 1945

Thomas Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1944 to July 2, 1945, and that I last saw him alive on July 2nd 1945.

Immediate cause of death
Pneumonia
Due to Pneumonia
Due to
Other Conditions Arterio-Sclerosis Senile
(Include pregnancy within 3 months of death)

Duration
4 days
over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Dronenfield
Address 1821 Eutaw Pl Date signed 7/7/46

G30351

BALTIMORE CITY HEALTH DEPARTMENT G30351
Registered No.

CERTIFICATE OF DEATH V13 1a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cooperation is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1851 Harford Avenue
(c) Hospital or institution: 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1851 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME May M. Stuart

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles E. Stuart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	29	##### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Wood
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eleanor Carter
15. Birthplace Baltimore, Md.

16 (a) Informant Milton R. Stuart (Son)
(b) Address Route 15, Box 190, Balto: Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location 7225 Eastern Ave. Balto;

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Ave; Balto; Md

19 (a) 7-2-1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to June 30 1945.
and that I last saw h[illegible] alive on June 28 1945

Immediate cause of death
Cardiac Insufficiency
Due to Arteriosclerosis.
Due to Hypertension
Other Conditions Chr. Nephritis
(Include pregnancy within 3 months of death)

Duration
?

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1761 E Mt. St. Date signed 7/2/45

X

G30352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G30352 Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1114 S. Charles St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1114 S. Charles St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Susan M. Robinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John T. Robinson

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 19 - 1885

8. AGE: Years	Months	Days	If less than one day
60	2	12	hr. min.

9. Birthplace Warrenton Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. H. Robinson

13. Birthplace Warrenton Va.

MOTHER 14. Maiden Name Frances Harrell

15. Birthplace Warrenton Va.

16 (a) Informant John A. Robinson

(b) Address 1425 S. Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-45 (month) (day) (year)

(c) Cemetery or crematory Marshal Cemetery

Location Marshall Va.

18 (a) Funeral director Elizabeth Hark Geo.

(b) Address 115 E. West St.

JUL 6 1945 Huntington Williamsport, Md. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to July 1 1945 and that I last saw her alive on July 1 1945

Immediate cause of death	Duration
Acute Dilatation of Heart	2 Days
Due to Mitral Regurgitation	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. R. Campbell M. D.

Address 16 S. Hanover St Date signed 7/5/45

VS 150

G30353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G30358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 908 N. Mount Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shirley Marie Cotton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/24/30

8. AGE:

Years	Months	Days	If less than one day
15	-	6	hr. min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Chas. E. Thomas

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Cotton

15. Birthplace Md

16 (a) Informant Elizabeth Cotton

(b) Address 908 Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/43 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wes. H. Nelson

(b) Address 1945 Pennsylvania Ave

JUL 2 1945

19 (a) (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION 6:18-

20. DATE OF DEATH June 30, 1943, at P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Purulent Peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard Weems M.D. Medical Examiner.

Date signed July 1, 1943.

VS 151

W Fisher G30354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G30354 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Un. Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No 1374 W Whalcoa St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard L. Wallace

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/1944

8. AGE: Years	Months	Days	If less than one day
	6	—	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Theodore Wallace
13. Birthplace Md

MOTHER
14. Maiden Name Virginia Evans
15. Birthplace Charlestown S.C.

16 (a) Informant Louise Evans
(b) Address 1374 W Whalcoa St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1803 Presstman St

19 (a) 7-2-1945 (b) Filed [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1945, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944, to June 30 1945, and that I last saw him alive on June 30 1945.

Immediate cause of death	Pneumonia	
Due to	Acute Meningitis (Suppurative)	
Due to	Basilar fracture	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles Drake M. D.
Address Univ Hosp Date signed 6-30-1945

VS 150

G30355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

Registered No. G30355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address 903 Ridgely St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Ridely St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LOLLIS · B · HEISCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband ~~or wife~~ Charles

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Oct 21st 1904

8. AGE: Years	Months	Days	If less than one day
40	8	8	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name	Howard Ziegler SR
FATHER — 13. Birthplace	Balto Md
MOTHER — 14. Maiden Name	Cora Miller
MOTHER — 15. Birthplace	Balto Md

16 (a) Informant Chas Heisch
(b) Address 1037 Ridgely St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 1-sec. Lot

18 (a) Funeral director Geo H. Leyenbach
(b) Address 525 N. Eutaw St

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

2-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29th 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10th 1945, to June 29 1945, and that I last saw h~~er~~ alive on June 29th 1945.

Immediate cause of death Carcinoma of Stomach — Duration 4 Months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Yates M. D.

Address 517 Scott St. Date signed 7/2/45

G30356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G30356

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Gwynn's Falls Pkwy.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Gwynn's Falls Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Maloney Morris

3 (b) If veteran, name war ----------

3 (c) Social Security Account No. ----------

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ##### Eugene M. Morris
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1859

8. AGE: Years 85 | Months 7 | Days 8 | If less than one day --- hr. --- min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business ----------

FATHER
12. Name James Maloney
13. Birthplace Ireland

MOTHER
14. Maiden Name ----- Aspel
15. Birthplace Ireland

16 (a) Informant Mr. Edward J. Morris
(b) Address 3414 Gwynn's Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery ######## New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

No. 2 Va 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 4 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to July 1945 and that I last saw h[illegible] alive on June 29 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions Prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Devaughn
Address 3841 Rafle St. Date signed 7/7/45

X

G30357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30357 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Hollins St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME William Heisler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth Heisler

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) February 23 1869

8. AGE: Years 76 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Retired

FATHER 12. Name Christian Heisler

13. Birthplace Germany

MOTHER 14. Maiden Name Eva

15. Birthplace Germany

16 (a) Informant Elizabeth Heisler

(b) Address 2518 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director Geo. L. Schwab

(b) Address 210 Frederick Ave

19 (a) Date received by local registrar JUL 3 1945 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 1 1945 and that I last saw him alive on July 1 1945.

Immediate cause of death	Duration
Cardio-Vascular Disease	2
Due to	
Due to	
Other Conditions Arterio Sclerosis	5

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Gerstenberg M. D.

Address 2427 Eutaw Pl Date signed July 4 1945

G30358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30358

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2837 Greenmount Ave

(c) Hospital or institution: Mercy

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2837 Greenmount Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elsie P Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 66 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Dressmaker

11. Industry or business

FATHER

12. Name Henry R. Walker

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Emilia J Lauber

15. Birthplace Pennsylvania

16 (a) Informant Mrs Edna W Dunkle

(b) Address 2837 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location

18 (a) Funeral director Mary W Redfield

(b) Address 501 E 22nd St

19 (a) JUL 3 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/1945 at 8:00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to July 1 1945 and that I last saw h[illegible] alive on June 29 1945

Immediate cause of death	Duration
Myocarditis and Pneumonia	2 hrs
Due to Myocarditis	6 mos
Due to Enlarged Arteriosclerosis	6 mos
Other Conditions Cachexia due to Senile and Terminal malignancy	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Howard White M.D.

Address 532 E 22nd St Date signed 7/2/45

X

630359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190a

Registered No. 630359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town St. Leonards
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Lynn Hatton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1944

8. AGE: Years | Months: 8 | Days: 5 | If less than one day: hr. min.

9. Birthplace Calvert Co., Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alonza Hatton

13. Birthplace Md

MOTHER 14. Maiden Name Velma Milling

15. Birthplace Md

16 (a) Informant Alonza Hatton

(b) Address St. Leonards, Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 4, 1945 (month) (day) (year)

(c) Cemetery or crematory Watts Memorial

Location Island Creek, Md

18 (a) Funeral director A. A. Hardesty & Son

(b) Address Mutual, Md

19 (a) Date received by Registrar JUL 9 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 6A. M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute bacto-enteritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Maddux M.D.
Medical Examiner.

Date signed July 7, 1945.

G30360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓112

Registered No. G30360

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 W. Ostend st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 W. Ostend st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Townsend

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of ~~husband or~~ wife: Nettie V. Townsend
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 20 1883
8. AGE: Years 61 | Months 11 | Days 11 | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Glass Cutter

FATHER
12. Name: William Townsend
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Laura Porter
15. Birthplace: Md.

16 (a) Informant: Mrs Lillian V. Lincoln
(b) Address: 1301 W. Ostend st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) (b) Huntington Williams Mort
Date rec'd by JUL 3 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1943 to June 30 1945, and that I last saw h[illegible] alive on June 30 1945.

Immediate cause of death: Bronchial Asthma — Duration

Due to: —

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature: Carl P. Rotting, M.D.
Address 1316 W Lombard st Date signed 7/5/45

X

G30361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30361

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Ford Lights & Route (If rural give location of City at Town)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian E Gittings

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Alida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1874

8. AGE: Years: about 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Cecil Co Md (Town, county, and state)

10. Usual Occupation Cost Acct

11. Industry or business A & E Ry

FATHER
12. Name Samuel E Gittings
13. Birthplace Long Green Md

MOTHER
14. Maiden Name Isabella Constable
15. Birthplace Cecil Co Md

16 (a) Informant Thomas M Gittings
(b) Address Worthington & Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Tilburn Lovelace
(b) Address 1219 N Fulton Ave

19. JUL 3 1945 (Date received by local reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 1 1945, and that I last saw him alive on June 30 1945.

	Duration
Immediate cause of death: Myocarditis	6 weeks
Due to: Advanced arteriosclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hallie S Dunbar M. D.
Address 2220 Garrison Blvd Date signed 7/1/45

VS 190

630362

S/S Ole Bull, Res 93 Fenton

630362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Sweden
(c) City or town Joenkalping (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Sweden

3 (a) FULL NAME Axel Edwin Goebel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1894

8. AGE: Years	Months	Days	If less than one day
50	10	18	hr. min.

9. Birthplace JAKOPING SWEDEN (Town, county, and state)

10. Usual Occupation MARINER

11. Industry or business

MOTHER FATHER

12. Name Unknown Goebel

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant Ida Conrad, VIRGINIA

(b) Address BALTO MD

17 (a) Cremation (b) Date thereof 7/3/45 (month) (day) (year)

(c) Cemetery or crematory GREEN MOUNT

Location Balto MD

18 (a) Funeral director Fallon Co Inc

(b) Address 1210 E Fayette St

19 JUL 3 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945 at 10 A.M. 30

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized Peritonitis

Due to Ruptured ulcer of small Bowel

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Traitzer M.D. Medical Examiner.

Date signed June 28 1945

VS 151

G30363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30363

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 E Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Matthews Dowson

3 (b) If veteran, name war: NA
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie M Dowson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 21 1864

8. AGE: Years 80 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Art Dealer
11. Industry or business: Gallery

FATHER
12. Name: Nelson Dowson
13. Birthplace: Easton Md

MOTHER
14. Maiden Name: Mary J Matthews
15. Birthplace: Baltimore Md

16 (a) Informant: Isaac Walter
(b) Address: Gunston Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory: Friends Burying Ground
Location: Baltimore Md

18 (a) Funeral director: Nelson Evans Sons
(b) Address: 1217 E Fort St

JUL 3 - 1945 (Date rec'd by registrar)
Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1944 to 6/30 1945 and that I last saw him alive on 6/30 1945

Immediate cause of death: Arteriosclerotic Coronary

Due to: Arteriosclerosis

Due to: Age; Very Feeble,

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Howard H Jr MD
Address: 1214 Charles Date signed: 7/3/45

VS 150

G30364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

Registered No. G30364

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Whitelock St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence May Beaumont

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female | 5. Color of race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Eugene Beaumont
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1872

8. AGE: Years 72 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick May
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Eugene Beaumont
(b) Address 600 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Wilson Carline
(b) Address 1219 E. Fayette St

JUL 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1945 to 6/30 1945 and that I last saw h. alive on 6/30 1945

Immediate cause of death: Hemiplegia — Duration 2 Days
Due to Anterior Cerebral Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. [illegible] M.D.
Address 2020 N. Charles Date signed 7/2/45

VS 150

630565 630565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Enson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Enson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Murphy

3 (b) If veteran, name war No
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Harry H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1879

8. AGE: Years	Months	Days	If less than one day
65	9	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Sylander
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Thurman
15. Birthplace Germany

16 (a) Informant Mrs Mary Kenly
(b) Address 6531 Ainsworth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Milburn Gordon
(b) Address 1217 E Fayette St

19 JUL 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945 to 7/1 1945, and that I last saw h[er] alive on 7/1 1945.

	Duration
Immediate cause of death Coronary Thrombosis	5 min
Due to Arteriosclerotic Cardiovascular Disease	?
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E Preston St Date signed 7/2/45

VS 150

G30366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/64

Registered No. G30366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES R ADAMS

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1944

8. AGE: Years 5 Months Days 26 If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leo F. Adams
13. Birthplace Lancaster Pa

MOTHER
14. Maiden Name Hilda E. Lemon
15. Birthplace Balto. Md.

16 (a) Informant Leo F. Adams
(b) Address 803 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUL 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 9:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymicus
Lymphaticus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratantoni M.D.
Medical Examiner.
Date signed July 2nd 1945

VS 151

G30367 G30367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.A. St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Hartford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Herdel

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 30 1860

8. AGE: Years	Months	Days	If less than one day
84	8	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name John Herdel
13. Birthplace Germany

MOTHER
14. Maiden Name Kumlgumda?
15. Birthplace Germany

16 (a) Informant Mrs. Agnes Voeth
(b) Address 307 Mockingale Ave.

17 (a) Burial (b) Date thereof July 5 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel County

18 (a) Funeral director William Cook Dec
(b) Address 1217 St. Paul St.

19 (a) JUL 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1945, at 6.00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 7/2/45

VS 151

G30368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30368 Registered No. 179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 W. Lafayette Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Van Dyke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1943.

8. AGE: Years	Months	Days	If less than one day
1 1/2	7	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilbur Cullington
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Van Dyke
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth Van Dyke
(b) Address 1321 Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-'45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 722 N. Pulaski St.

19. JUL 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 10:50 A.M. P.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tri-sodium Phosphate Poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-1- at P. M.
(b) Where did injury occur? 1321 W. Lafayette Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed Tri-Sodium Phosphate Cleaner

23. Signature Howard J. Claudius M.D.
Medical Examiner.
Date signed 6-2-45

VS 151

G30369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G30369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 Forrest St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA GEORGE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ WILBERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 27, 1864

8. AGE: Years 81 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace BALTO. Md.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business OWN HOME

FATHER
12. Name ? HAMILTON
13. Birthplace Md.

MOTHER
14. Maiden Name ROSE (UNKNOWN
15. Birthplace Md.

16 (a) Informant STEPHEN H. GEORGE
(b) Address 1023 FORREST ST

17 (a) BURIAL (b) Date thereof 7-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE, Md.

18 (a) Funeral director William Cook Co.
(b) Address 1217 Lafayette Ave. Huntington Pittsburgh

19 JUL 3 1945 (b) Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/45 19 , at 2 P. M.

21. I certify that I took charge of the remains described above, held an Inspection of Autopsy and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 7/3/45

G30370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G30370

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 229 Silver St

(c) Hospital or institution: 51

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 229 Silver St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sophia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-5-1903

8. AGE: Years 42. | Months 1 | Days 25. | If less than one day hr. min.

9. Birthplace A. A. County Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name Richard Hall

13. Birthplace Md

MOTHER 14. Maiden Name Margret ?

15. Birthplace Md

16 (a) Informant Mary Spencer

(b) Address 214 Silver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)

(c) Cemetery or crematory Mayotta Cem

Location A. A. County Md

18 (a) Funeral director Wm A. Jackson

(b) Address 916 Pedpa ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUL 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945, at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to 6-30 1945

and that I last saw him alive on 6/28 1945

Immediate cause of death Cerebrovascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration Between Onset and Death
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address 1202 N Carlin St Date signed 7/2/45

X

D 30371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G 30371.

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1543 Penna ave
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1543 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Overby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-21-1873.

8. AGE: Years 69 | Months 11 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace South-Boston Va
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Alex Crawley
13. Birthplace Va

MOTHER
14. Maiden Name Hattie Atkins
15. Birthplace Va

16 (a) Informant Florence Terry
(b) Address 1543 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Stephens & Jackson
(b) Address 916 Penna ave

19 (a) Date received JUL 3 1945 (b)

Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 8.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to July 1 1945, and that I last saw h[illegible] alive on July 1 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius S White M. D.
Address 1543 Penna Ave Date signed 7-2-45

Huntington Williamsville, W Va

X

G30372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30372

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Mt. Rainer
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Otis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE D. FRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva C. (Cranmer) Fry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	11	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business U. S. Navy Yard

FATHER
12. Name Samuel Fry
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Sophia M. Phile
15. Birthplace Wash., D. C.

16 (a) Informant Mrs. Eva C. Fry
(b) Address 3302 Otis St., Mt. Rainer, Md.

17 (a) Burial (b) Date thereof 7/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln Cem.,
Location Wash., D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. JUL 3 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to July 1 1945 and that I last saw him alive on June 29 1945.

Immediate cause of death	Duration
Myocarditis	15 days
Due to Arteriosclerosis	?
Due to Cerebral hemorrhage & paralysis	7 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Fuchs M.D.
Address 2220 Garrison Blvd. Date signed 7/3/45

G30373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1216

Registered No. G30373

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1728 Warwick Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Warwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY LEE WOLSH

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-01-4904

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1915

8. AGE: Years	Months	Days	If less than one day
29	8	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William A. Wolsh
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ella Grace Ford
15. Birthplace Balto., Md.

16 (a) Informant Mr. William A. Wolsh
(b) Address 1728 Warwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address [illegible] Md.

19 (a) JUL 3 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 1, 1945 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/28 1944 to 7/1 1945 and that I last saw her alive on 7/1 1945

Immediate cause of death: Chronic nephritis. — Duration: 3 yrs.
Due to
Due to
Other Conditions: Chronic Valvular Heart
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature [signature] M.D.
Address 2020 N. Charles Date signed 7/2/45

VS 150

G30374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G30374 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St -
(c) Hospital or institution:
Home for Incurables -
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3131 O'Donnell St
(If rural give location)
(e) Citizen of foreign country? Yes - (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Thomas -

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White -	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 - 1866

8. AGE: Years	Months	Days	If less than one day
78	6	25	hr. min.

9. Birthplace Pottsville - Pa -
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas D. Thomas
13. Birthplace Wales. Great Britain

MOTHER
14. Maiden Name Jane Davis
15. Birthplace Wales -

16 (a) Informant Home for Incurables
(b) Address 700 W. 40th St (HRB

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director Chas. J. Tschudi & Son
(b) Address Balto. Md.

19 (a) (Date rec'd by registrar) (b) Huntington for Williams, MD Registrar

JUL 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1938, to 6/29 1945, and that I last saw h alive on 6/29 1945.

Immediate cause of death	Duration
Hypertensive Cardio -	
Scattered Renal Pneum	8 years
Due to	
Due to	
Other Conditions Arteriosclerosis	20 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Wenzgen

Address 214 Medical Arts Bldg Date signed 6/29/45 M. D.

X

G30375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS HEAVY LINE MUST BE ERASED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3032 Ascension Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3032 Ascension Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eater Ruth Scurry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 1 | Days | If less than one day: hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY JUN 26 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 3 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1945 at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to less death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ignanition.
Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Roland Cu Frazier M.D.
Medical Examiner.

Date signed June 13 1945

VS 151

G30376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

G30376

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 [redacted] Calvert Ste.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (years ~~months~~ or days) 12
(e) Length of stay in Baltimore (years ~~months~~ or days) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Monkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (~~Witness~~ No)
If yes, name country

3 (a) FULL NAME Mrs. [redacted] Ball (Lillian Agnes)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or ~~wife~~ Ernest Edward Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/11/1882

8. AGE: Years	Months	Days	If less than one day
63	10	28	hr. min.

9. Birthplace Maryland (town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Whitty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Corrigan
15. Birthplace Ireland

16 (a) Informant Mrs. Maria Morris (daughter)
(b) Address Monkton, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Md.

18 (a) Funeral director Sander M. Bowles
(b) Address Sparks Md

19 (a) (Date received by Registrar) JUL 3 - 1945 (b) Huntingtown Calvert Co. Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945 at 6 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1945 to 7/3 1945, and that I last saw her alive on 7/2 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	2 days
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/24/45
Major findings of operation: Old cesarean section, Central hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm W. Hodges M.D.
Address Union Memorial Hosp. Date signed 7/3/45
M.D.

G30377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G30377

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Rupprecht.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-86.

8. AGE: Years	Months	Days	If less than one day
58	10	29	hr. min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Rupprecht
13. Birthplace Germany.

MOTHER
14. Maiden Name Madgelein
15. Birthplace Germany.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 2 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 3 1945 (b) Hunter Van Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1945 to June 25 1945, and that I last saw h[illegible] alive on June 25 1945

Duration
Immediate cause of death: Cerebral hemorrhage
Due to: Hypertensive Cardio-
Due to: Arteriosclerosis
Other Conditions: Late latent syphilis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gabriel A. Lance M.D.
Address Hopkins Date signed 6/29/45

VS 100

2805 93D

G30378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30378 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D. H.
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4716 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chester S. Blake

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Amy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct 10 1886
8. AGE: Years 58 | Months 8 | Days 21 | If less than one day hr. min.
9. Birthplace North East Md (Town, county, and state)
10. Usual Occupation Master Mechanic
11. Industry or business Mohawk Lubricating Co

FATHER
12. Name Thomas Blake
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Chester Blake
(b) Address Upland Pa

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Ashton, Md

18 (a) Funeral director Williams & Son Inc
(b) Address 1214 E Pratt St

19 Filed JUL 3 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1 1945, at 6:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. H. Schumacher M.D. Medical Examiner.
Date signed 7/2/45

VS 151

G30379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D. of A.
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Hahn

3 (b) If veteran, name war: 70
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elizabet M. nee Wernich
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 30 187[illegible]
8. AGE: Years 75 | Months | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Bar O

FATHER
12. Name Adam Hahn
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Griesacker
15. Birthplace Balto. Co. Md.

16 (a) Informant Elizabeth M. Hahn
(b) Address 807 W. Fayette St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director M. M. E. Dippel's Son
(b) Address 600 Lombard - 400 N. St.

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams Medical Examiner

JUL 5 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Kopelowitz M.D. Medical Examiner.
Date signed 7/2/45

G30380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30380 Registered No. 1701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give County)
(d) Street No. 1314 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Cates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) 6-10-1907

8. AGE: Years 38 | Months — | Days 20 | If less than one day ___ hr. ___ min.

9. Birthplace North Carolina (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James H Cates
13. Birthplace N.C.

MOTHER
14. Maiden Name Daisy Long
15. Birthplace N.C.

16 (a) Informant Ernest Cates
(b) Address 1510 Madison ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)

(c) Cemetery or crematory Rougemont Cem
Location Rougemont Durham Co. N.C.

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna Ave

19 (a) (Date rec'd by registrar) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 45 - 19 , at 9:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: N-1

(a) Date of injury 6-30-45 at 6 P.M.
(b) Where did injury occur? S. on Pilger St. & Baker St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in car that struck lamp post

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed July 4, 1945

VS 151

X

G30381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G30381

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2466 Keyworth Ave

(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2466 Keyworth Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Barnett Ratzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name Samuel —

13. Birthplace Russia

MOTHER

14. Maiden Name Celia —

15. Birthplace Russia

16 (a) Informant Mrs Lena Ratzer

(b) Address 2466 Keyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)

(c) Cemetery or crematory Workmen Circle

Location Shelley Mt. Carmel

18 (a) Funeral director Jacob Levin Inc

(b) Address 1431 E. Balto St

Date received 7-2-1945 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-45 19 , at 5A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942, to July 1, 1945, and that I last saw him alive on July 29 45.

Immediate cause of death: Carcinoma of rectum — Duration 3½ yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Nathan B. Eliasberg M. D.

Address 1041 St. Paul St. Date signed 7-2-45

G30.382

30382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME ROSE BRAVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Max

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 74 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Harford & Fowblings Lane

18 (a) Funeral director Jack Lenz Inc
(b) Address 1439 E. Balto St

(a) JUL 3 1945 (Date received by Registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 3 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to July 2 1945 and that I last saw h[illegible] alive on July 2 1945

Immediate cause of death	Duration
Bronchopneumonia	
Due to cerebral thrombosis	
Due to	
Other Conditions Potts disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Kern M. D.
Address Lutindale Date signed

838

G30383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

Registered No. G30383

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 No Bentelow St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write "RFRA" and give town)
(d) Street No. 1805 No Bentelow St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Talmaz
13. Birthplace Russia

MOTHER
14. Maiden Name Fargh Etta
15. Birthplace Russia

16 (a) Informant Simon Jacobson
(b) Address 1805 No Bentelow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory New Cup Friendship
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto St

19 Filed July 3 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to July 1 1945 and that I last saw h alive on July 1 1945.

Immediate cause of death	Duration
Cardiac Decompensation	6 mos
Due to Cardiac Hypertrophy & Dilatation	10 years.
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Simon Coopersmith M.D.
Address 2701 Eutaw Place Date signed 7/2/45

VS 150

G30384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 163a

G30384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Bryant ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Bloombaum

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Kleenman

13. Birthplace Russia.

MOTHER 14. Maiden Name Fraina

15. Birthplace Russia.

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Rd

Location Windsor Mill Rd

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) JUL 3 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2- 1945, at 11 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arsenic Toxicide Poisoning

Due to

Other Conditions Mental Case.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6-27- at a. M.

(b) Where did injury occur? 2016 Bryant Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Ingestion of Poison

23. Signature Howard J. Williams M.D. Medical Examiner.

Date signed 7-2-45

G30385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G30385

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State California (b) County
(c) City or town Los Angeles (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 S. Oxford (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Dixon A Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 9-3-39

8. AGE: Years	Months	Days	If less than one day
5	9	29	____ hr. ____ min.

9. Birthplace Washington (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Dixon S. H Johns
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Lillian Mc Connell
15. Birthplace Ohio

16 (a) Informant Dixon S. Kelly
(b) Address Los Angeles, Cal.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/43 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Los Angeles, Cal.

18 (a) Funeral director John D. Metcalfe Sons Inc
(b) Address 600 Eutaw Place

19 (a) Date 3 JUL 1945 (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1943 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1943 to 7-2 1943
and that I last saw him alive on July 2 1943

Immediate cause of death
Operation for relief of pulmonary stenosis
Due to Congenital malformation of heart
Due to Very extreme stenosis of pulm. (Valve in diameter)
Other Conditions none
(Include pregnancy within 3 months of death)

Duration

Date of operation 7/2/43
Major findings of operation: Tetralogy of Fallot with enlarged heart + stenosis pulm.
Date of autopsy: ____ Was autopsy performed? yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen B Taussig M.D.
Address J. H. Hospital Date signed 7/3/43

VS 150

G30386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G30386 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Hoffman St,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Hoffman St. (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Hawkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24 1905

8. AGE: Years	Months	Days	If less than one day
40	2	8	hr. min.

9. Birthplace Lawrence, S. Carolina (Town, county, and state)
10. Usual Occupation Beautician
11. Industry or business

FATHER
12. Name Samuel Woody
13. Birthplace South Carolina

MOTHER
14. Maiden Name Carolyn Scott
15. Birthplace South Carolina

16 (a) Informant Carolyn Scott
(b) Address 504 Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory Clinton
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Registrar

JUL 3 - 1945

VS 380

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 1 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from May 31 1945 to July 2 1945 and that I last saw h[illegible] alive on July 2 1945

Immediate cause of death Uremia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 7 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 754 Druid Hill Ave Date signed 7-5-45

630387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. 630387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital. D.B.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Flynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 28, 1938.

8. AGE: Years	Months	Days	If less than one day
6 yrs	9	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation School-boy.

11. Industry or business

FATHER
12. Name George Flynn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hilda Long
15. Birthplace Baltimore Md.

16 (a) Informant George Flynn (Father)
(b) Address 3706 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Colm.
Location German Hill Rd, Md.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 JUL 3 - 1945 (Date Rec'd by Registrar) (b) Huntington, Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1945, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Accidental Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1/3

(a) Date of injury 7/4/1945 at about 12:30 P M.
(b) Where did injury occur? Patterson Pk. Swimming Pool
(c) Did injury occur at home, on farm, industrial place, in public place? Public Pool While at work? No
(d) Means of injury Drowning

23. Signature C. J. Gulvin M.D. Medical Examiner.
Date signed 7/6/45

VS 151

G30388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30388 / 93D

Registered No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 4303 Wilshire Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Wilshire Ave
(If rural give location)
(e) Citizen of foreign country? Wilshire (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Plasser

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Leonard Plasser
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Sept 16 15

8. AGE: Years	Months	Days	If less than one day
79	9	15	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Henry Dan Koneffer
13. Birthplace Bermuda

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Helen M. Smith
(b) Address 4303 Wilshire Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director Wells Funeral Home
(b) Address 2004-8 Orleans St

19 (a) Interior for Williams MD (Date rec'd by registrar) Registrar
JUL 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 6 45 P M

21. I certify that I took charge of the remains described above, held an Inspection Inquest on and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V disease

Due to —

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] Medical Examiner M.D.
Date signed 7/1/45

G30389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30389 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 S. Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S. Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Maeth

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-9230

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.) July 10 1867

8. AGE: Years	Months	Days	If less than one day
77	11	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Schluderberg & Kurdle

FATHER
12. Name Henry G. Maeth
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Eckert
15. Birthplace Baltimore

16 (a) Informant Margaret Maeth.
(b) Address 530 S Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 (month) (day) (year)
(c) Cemetery or crematory Pat Woodlawn Cem
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2005 Aliceanna St

19 (a) (Date rec'd by registrar) (b) Registrar

VS/(9) JUL 3 - 1945 Huntington Hall, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 7 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 7-2-45

G30390 G30390

AB- 93466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos-24days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry La Motte or Harrison H. Lamotte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 12- 1884

8. AGE: Years	Months	Days	If less than one day
60	9	17	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George La Motte
13. Birthplace Md.

MOTHER
14. Maiden Name Sara McClellan or McClellwen
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 '45 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Hampstead Md

18 (a) Funeral director Edw. C. Tipton
(b) Address Hampstead Md

19 JUL 3- 1945 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29- 1945, at 9.25PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1945, to 6-29- 1945 and that I last saw h im alive on 6-29- 1945.

Immediate cause of death At lower lobes Pneumonia — Duration 2 mo?

Due to organism not determined

Due to

Other Conditions Arterio Sclerosis, generalized years
T. Laparotomy (Include pregnancy within 3 months of death)

Date of operation 6-7-45 (Van Buren operation)

Major findings of operation: First degree rectal prolapse.

of autopsy Same. Plus diverticulosis of colon, & Uterine fibroids.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johnson J. O'Neill M. D.
Address Baltimore City Hospitals Date signed 7-3-45

VS 150

G30891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G30891 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 N. Caroline Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WILLIAM VOLLMER

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mazie D. Vollmer

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1873

8. AGE: Years 71 | Months 10 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Baltimore Copper paint Co.

FATHER
12. Name Henry W. Vollmer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Eckert
15. Birthplace Germany

16 (a) Informant Mrs. Mazie Vollmer
(b) Address 1718 N. Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 JUL 3 - 1945 Huntington Station, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug '44 19... to July 1 1945 and that I last saw h[illegible] alive on July 1 1945.

Immediate cause of death: Carcinoma of Sigmoid Colon — Duration 5-6 yrs.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operations Sept 1944 Dec 1944

Major findings of operation: (Accurately)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. D. Lyon M. D.
Address 1 E Baltimore Pk Date signed 7/2/45

X

G30392 G30392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 E. Fairmount ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET ANNA LAMBDIN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Frederick Talbott Lambdin
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): Oct. 17. 1882
8. AGE: Years 62 | Months 8 | Days 15 | If less than one day ____ hr. ____ min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

MOTHER / FATHER
12. Name: John D. Johnson
13. Birthplace: Baltimore
14. Maiden Name: Elizabeth Zimmerman
15. Birthplace: Baltimore

16 (a) Informant: Mr. Frederick T. Lambdin
(b) Address: 3102 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jul. 8. 1945 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: Baltimore
18 (c) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: North Ave. & Broadway.
19 (a) ____ (b) Huntington Millhauser, M.D. Registrar
(Date received by registrar) JUL 3 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2 1945, at 1 02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945, to 7-2 1945, and that I last saw her alive on 7-2 1945.

	Duration
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other Conditions: arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: M.E. Robertson M. D.
Address: St Josephs Hosp Date signed: 7-2-45

G30393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G30393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2904 E. Pratt St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2904 E. Pratt St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA V. HORST.

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19. 1865

8. AGE: Years 80 | Months 2 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Horst
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Butschky
15. Birthplace Baltimore

16 (a) Informant Miss Elizabeth Horst
(b) Address 2904 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul. 3. 1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.

(b) Address North Ave. & Broadway.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 JUL 3 - 1945 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH June. 30. 1945 at 10.30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 44 to Jun 30 1945 and that I last saw her alive on Jun 29 1945.

Immediate cause of death Pulmonary Edema — Duration

Due to Tuberculosis

Due to

Other Conditions Pulm. Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ✓

(b) Date of occurrence ✓ at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)

(e) Means of injury

23. Signature Chas T Blake M. D.

Address 20 E Preston Date signed 7/2/45

X

G30394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G30394 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Bruce St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Boyer (Green)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband ~~or wife~~ Ernest Boyer

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) — 1899

8. AGE: Years 46 | Months | Days | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Leach
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie —
15. Birthplace Md.

16 (a) Informant Mamie A. Warren
(b) Address 642 Peckford Pl. N.E. Washington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location West Baltimore, Md.

18 (a) Funeral director Geo. W. Kelson
(b) Address 1003 Pennsylvania Ave.

19 (a) [redacted] 3 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 A.M. 1945 to July 1 1945 10:25 A.M. and that I last saw her alive on July 1 1945 A.M.

Immediate cause of death	Uremia	
Due to	Chronic glomerular nephritis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Doreas Clark M. D.
Address University Hosp. Date signed July 2 1945

VS 150

G30395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G30395

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Booth St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Booth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella J. Rogers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Edgar Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13: 1880

8. AGE: Years 64 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Edward Chaney
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna McKenzie
15. Birthplace Baltimore Md

16 (a) Informant Mrs Martin Walfe
(b) Address 2209 Booth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Theo J. Kenny
(b) Address Hollins & Belnord

19 (a) (Date signed by registrar) JUL 3 1945 Hunting Town Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1945, at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945 to June 30 1945, and that I last saw her alive on June 30 1945.

Immediate cause of death	Duration
Myocardial degeneration	?
Due to Cerebral Embolism.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. C. Donoghue M.D.
Address 1905 W. Balto. Date signed 7/3/45 M. D.

VS 180

G30396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G30396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 N. Nolan (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roderick Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-45

8. AGE: Years | Months: 5 6 | Days: 20 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Brown.
13. Birthplace N. C.

MOTHER
14. Maiden Name Effie E.
15. Birthplace N. C.

16 (a) Informant Parents.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryant Ln Balto

19 (a) 7-3-1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 2 1945, and that I last saw h alive on July 2 1945.

Immediate cause of death	Duration
Acute Nutritional Disturbance	4 days
Due to Pneumonia	1 day
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena A. Hall Asst Resident
Address Hopkins Hospital Date signed 7.2.45

VS 150

A42027 G30397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190 G30397

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin Counts
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	black	S -

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29 1944

8. AGE: Years	Months	Days	If less than one day: hr.	min.
	7	1		

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Counts
13. Birthplace ?

MOTHER
14. Maiden Name Florence
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Broadway ave

19 (a) 1945 (b) Huntington Williams Registrar
(Date received by registrar)

VS 199

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 - 1945, at 8 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30-1945 to 6-30-1945 and that I last saw him alive on 6-30-1945

Immediate cause of death	Duration
Dehydration	1 day
Acidosis	
Due to Acute Nutritional	2 days
Due to Disturbances	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Romaine A. Hall M. D.
Address Hopkins Hospital Date signed 6-30-45

X

G30398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

G30398
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 S Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 S Charles St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William F Bramblett

3 (b) If veteran, name war None | 3 (c) Social Security Account No. no

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Madonna A Bramblett

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) March 10, 1866

8. AGE: Years 79 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name William F Bramblett
13. Birthplace Balto Md

MOTHER 14. Maiden Name Adelaide Sweezis
15. Birthplace Balto Md

16 (a) Informant William F Bramblett
(b) Address 1222 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Co. Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1205 S Charles St

19 (a) Date received July 3 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to July 2 1945 and that I last saw h alive on July 2 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days
Due to Arteriosclerosis	
Due to	
Other Conditions Left Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1224 S Charles St Date signed

7/2/45

G30399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

G30399 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 Williams
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 Williams (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter F. Wheeler.

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen B. Wheeler

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct 15 1879

8. AGE: Years 65 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business Self employed

FATHER 12. Name William F. Wheeler

13. Birthplace Md

MOTHER 14. Maiden Name Annie London

15. Birthplace Dent Kent

16 (a) Informant Helen B. Wheeler

(b) Address 1437 Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1945 (month) (day) (year)

(c) Cemetery or crematory Westview Cem

Location Baltimore

18 (a) Funeral director A. J. Howard & Sons

(b) Address 1402 S. Charles St

19 (d) 1945 [illegible] Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to July 2 1945 and that I last saw him alive on July 2 1945

Immediate cause of death Angina Pectoris — Duration 3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1279 William St Date signed 7/3/45

Dr M-- G30100
470-Nonreporting fee

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G30100
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 152 + Elmtree St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 152 + Elmtree St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha M. Dowgiallo

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Anthony J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1890

8. AGE: Years	Months	Days	If less than one day
55	2	9	hr. min.

9. Birthplace Vilna - Lithuania
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Dominick Lasiaski
13. Birthplace Lithuania

MOTHER
14. Maiden Name Mary Wiggirt
15. Birthplace Lithuania

16 (a) Informant Rev Vincent Dowgiallo
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location

18 (a) Funeral director C. J. Rock
(b) Address 5305 Harford Rd

19 (a) (Date rec'd) (b) Registrar

JUL 3 - 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to July 1 1945 and that I last saw her alive on June 28 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 wks
Due to Hypertension Emphysema
Due to
Other Conditions Hemiplegia — 2 wks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon D. Bourcia M. D.
Address 4700 Eliasville Pky Date signed 7/2/45

G30101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G30101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Justus Woernle WOERNLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife FANNIE C.

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Dec - 11 - 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	6	22		

9. Birthplace Germany
(Town, county, and State)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Kurt Woernle
(b) Address 3100 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director L. J. Rieck
(b) Address 5305 Harford Rd

19 (a) 7-3-1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/ 1944 to 7/2/ 1944, and that I last saw h. alive on 7/2 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Hypertensive Cardiovascular & Arteriosclerotic Heart disease

Due to

Other Conditions Cellulitis of RT Arm and Hand

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Justus Woernle
Address 1400 St Joseph's Hospital Date signed 7/2/45

VS 180

G30108

BALTIMORE CITY HEALTH DEPARTMENT ✓ G30108

CERTIFICATE OF DEATH 1179

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Southern Av,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon A Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-1341

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27-188

8. AGE: Years 63 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Balto- Md
(Town, county, and state)

10. Usual Occupation Pressman

11. Industry or business

FATHER 12. Name Charles E. Christopher

13. Birthplace Md

MOTHER 14. Maiden Name Mary A. Chamberlain

15. Birthplace Md

16 (a) Informant Mrs. Nellie Phelps

(b) Address Joppa - P.O. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)

(c) Cemetery or crematory Oakland

Location Md

18 (a) Funeral director J. Pugh

(b) Address 530 E Hoffman St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1945, at 3.10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Gastric Ulcer
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNulty M.D.
Medical Examiner.
Date signed 7/2/45

937

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30103 ✓ G30103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN BAKER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Ada E. Baker
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1870

8. AGE: Years: 74 | Months: 7 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: James Baker
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Elizabeth Huebeck
15. Birthplace: Germany

16 (a) Informant: Mrs. Jessie E. Heil
(b) Address: 1525 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem. Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) JUL 3 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 2 1945 and that I last saw h[illegible] alive on July 2 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Arteriosclerosis	
Due to	
Other Conditions Carcinoma of bladder	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney L. Levy M. D.
Address 2322 Eutaw Place Date signed 7/2/45

VS 190

93 D

G30404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G30404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 North Monroe
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 North Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (ER) Capt. John M. Busselle

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1879

8. AGE: Years	Months	Days	If less than one day
65	9	29	hr. min.

9. Birthplace Lancaster Co., Va. (Town, county, and state)
10. Usual Occupation Sea Captain
11. Industry or business Bull Steamship Co.

FATHER
12. Name John Busselle
13. Birthplace Va.

MOTHER
14. Maiden Name Georgia Flowers
15. Birthplace Va.

16 (a) Informant Mrs. Katherine S. Busselle
(b) Address 903 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 3 - 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/45 19 , at 8:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 7/3/45

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. 630105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Thelma Marie Watkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1942

8. AGE: Years	Months	Days	If less than one day
2	8	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Moses Watkins
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Massey
15. Birthplace Alabama

16 (a) Informant Virginia Watkins
(b) Address 1602 E Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md.

18 (a) Funeral director Mrs Robert J. Ellis
(b) Address 1129 N. Gardiner St

19 (a) (Date received by registrar) (b) Registrar

JUL 3 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1945 at 10:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1945 to 6/29 1945, and that I last saw her alive on 6/29 1945.

Immediate cause of death	Duration
Due to Pneumonia Lobar	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm A Bicker
Address 601 N. Calhoun St Date signed 7/3/45

2 Transcripts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 630:06

Registered No. 73a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Aulls St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Aulls St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie R. Matthews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4/87

8. AGE: Years 77 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Harris
15. Birthplace Md.

16 (a) Informant Ella Matthews
(b) Address 644 Aulls St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto. County Md

18 (a) Funeral director Wm. Robert A. Eldridge
(b) Address 1129 N. Carlton St

19 (a) (Date rec'd by Registrar) (b) Registrar

JUL 3 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st, 1945, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28/1945 to July 1st 1945, and that I last saw him alive on June 30 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Arteriosclerosis	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. W. Mooney Strayer M.D. M. D.
Address 4016 E. 25 Ave Date signed 7/3/45

VS 150

X

G30407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G30407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Morling Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Morling Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Sidney Shannon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Ada Shannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1874

8. AGE: Years 70 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Edward L. Shannon
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie —
15. Birthplace Maryland

16 (a) Informant Mrs. Emmett N. Bull
(b) Address 1330 Morling Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5-1945 (month) (day) (year)
(c) Cemetery or crematory M. Oliver
Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to July 2 1945 and that I last saw h[illegible] alive on July 2 of 45.

Immediate cause of death Congestive Heart Failure
Due to Arteriosclerotic C-V. Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: Several Years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Hessman M. D.
Address 4037 Falls Rd. Date signed 7/3/45

VS 150

X

G30:08

475126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

516

Registered No. G30:08

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Bristol (If outside city or town limits, write RURAL and give town)
(d) Street No. P. O. Box 196 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Walter Selfe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Jones.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 5-13-74.

8. AGE: Years	Months	Days	If less than one day
71	1	19	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Insurance Salesman.

11. Industry or business

FATHER
12. Name Wilson Selfe.
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Kiser.
15. Birthplace Va

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address Records.

17 (a) (Burial, cremation, or removal) (b) Date thereof July-6-1945 (month) (day) (year)
(c) Cemetery or crematory Bristol Cemetery
Location Bristol Tenn

18 (a) Funeral director [illegible]
(b) Address Baltimore Md

19 (a) July 3 1945 (Date signed by Registrar) (b) Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 11.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to July 2 1945 and that I last saw him alive on July 2 1945

Immediate cause of death: Sphacemia — Duration 1 wk

Due to

Due to

Other Conditions Carcinoma of Prostate (Include pregnancy within 3 months of death)

Date of operation [illegible]

Major findings of operation: Same

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H. Kinney M.D.
Address [illegible] Date signed 7/3/45

X

630:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

(Registered No.)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 789 W Mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 789 W Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-1900

8. AGE: Years 45 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Winnsboro, S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Bell
13. Birthplace Winnsboro, S. C.

MOTHER
14. Maiden Name Minnie Nelson
15. Birthplace Winnsboro S. C.

16 (a) Informant Ben. Stevenson
(b) Address 789 W. Mulberry St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7 (month) 3 (day) 45 (year)

(c) Cemetery or crematory
Location Winnsboro S. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Dolphin St

19 (a) JUL 9 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to June 30 1945
and that I last saw him alive on June 30 1945

Immediate cause of death
(a) Coronary Thrombosis

Duration: 18 Mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 322 N. Dolphin St Date signed 7-2-45

VS 150

Dr. Edgar Miller
1804 Rolling Road

G30110

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33a

Registered No. G30110

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Sheridan Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Payson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Krabbe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry Krabbe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1858

8. AGE: Years	Months	Days	If less than one day
86	8	4	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Bernard Schwerman
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Anna Smith
(b) Address 511 Sheridan Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b) Registrar
(Date rec'd by registrar)

JUL 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to July 1 1945 and that I last saw her alive on June 26, 1945.

Immediate cause of death	Duration
Influenza	7 days
Due to Broncho-pneumonia	24 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar G. Miller
Address X 23 Washington Blvd Date signed 7/3/45

Verified

X

G30111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G30111 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: South Baltimore Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Andre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P Brady

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ellen RISEN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Balto. (Town, county and state)

10. Usual Occupation Guard around boats

11. Industry or business

FATHER 12. Name Daniel Bradey

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Fahey

15. Birthplace Ireland

16 (a) Informant Annie Brownell

(b) Address 119 Burnett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)

(c) Cemetery or crematory Dr Hadra

Location Old Frederick Rd

18 (a) Funeral director Jos. Slaughter Sons

(b) Address 311 Light St.

19 JUL 3 1945 (Date received by Registrar) (b) Lexington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1945, at 6:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.

Date signed July 4, 1945.

G30112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30112 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John A. Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	25	hr. min.

9. Birthplace Winchester Va
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John McFarland
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Harvey
15. Birthplace Virginia

16 (a) Informant Mrs Bertha Hershey
(b) Address 1513 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Frederick & Cole
(b) Address 1206 W Lombard St

19 (a) 7/4/45 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1945 at 7:42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to July 1945, and that I last saw her alive on June 15 1945.

Immediate cause of death Chronic Myocardial Degeneration
Due to Arteriosclerosis
C.V. Disease

Duration
2 yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. P. Lehmann M. D.
Address 5217 Reisterstown Rd Date signed 7/2/45

X

G30113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G30113 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 S. Penn St.
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Penn St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Strobel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Frederick H. Strobel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1901

8. AGE: Years	Months	Days	If less than one day
43	8	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Earl Myers
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Beatrice Burns
15. Birthplace Ireland.

16 (a) Informant Mrs Rita Trimmer
(b) Address 111 S. Penn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof & (month) (day) (year)
(c) Cemetery or crematory Glenn Haven
Location Ritchie Highway, A.A. Co.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) 7-3-1945 (Date rec'd by registrar) (b) Funeral Home, Millersville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30th 1945 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to June 1945, and that I last saw h[illegible] alive on 6/29 1945.

Immediate cause of death
Acute Cardiac Dilatation
Due to
Due to a y Angy
Other Conditions Chronic

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
2y

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Sc C Fulton M.D.
Address 1440 E Balto Date signed 7/4/45

X

VS 180

G30114 ✓ G30114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 Newton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Newton Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Louisa Catherine Bowerson

3 (b) If veteran, name war —

3 (c) Social Security Account No. None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband ~~or wife~~ C. Edward Bowerson

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1869

8. AGE: Years	Months	Days	If less than one day
74	9	16	..... hr. ..... min.

9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joshua Stevenson
13. Birthplace Md.

MOTHER
14. Maiden Name Sabina Haas.
15. Birthplace Md.

16 (a) Informant Lillian E. Doherty
(b) Address 4103 Newton Ave

17 (a) Burial (b) Date thereof 7-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park.
Location Woodlawn Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 9.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1945 to July 1 1945, and that I last saw h[illegible] alive on July 1 1945.

Immediate cause of death	Duration
Cerebral Hemmorrhage	2 days
Due to Arteriosclerosis generalized.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature M. S. Lowman M. D.
Address 5013 Park Heights Ave Date signed 7/4/45

for Williams, M.D. Registrar

X

630115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 630115

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ. of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York
(c) City or town Hanover (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME CORA WILDASIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1885

8. AGE: Years 60 | Months 3 | Days | If less than one day hr. min.

9. Birthplace York county Pa (Town, county, and state)

10. Usual Occupation Employed Hanover Glove Co.

11. Industry or business

FATHER
12. Name William Wildasin
13. Birthplace York county Pa.

MOTHER
14. Maiden Name Sarah Ann Bechler
15. Birthplace York county Pa.

16 (a) Informant Sarah Wildasin
(b) Address 820 Baltimore St Hanover Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover Pa.

18 (a) Funeral director W. A. Feiser
(b) Address Hanover Pa.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar's signature for Williams, Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1945, at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 3, 1945 and that I last saw her alive on July 3, 1945

Immediate cause of death Cerebral hemorrhage — Duration 6 hours

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy L. Cox, Jr. M. D.
Address Univ. Hospital Date signed 7/9/45

VS 190

X

G30416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G30416

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 E. 24th St.
(c) Hospital or institution: The Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Fawcett Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James P. Walsh

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh. M	

6 (b) Name of husband or wife: Mrs. Anna L. Walsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7, 1903

8. AGE: Years	Months	Days	If less than one day
41	10	25	hr. min.

9. Birthplace Rhode Island.
(Town, county, and state)
10. Usual Occupation Merchant Marine
11. Industry or business Seaman

FATHER
12. Name Mr. Richard Walsh (Sr)
13. Birthplace Rhode Island.

MOTHER
14. Maiden Name Josephine
15. Birthplace Rhode Island.

16 (a) Informant Mrs. Anna L. Walsh
(b) Address 418 Fawcett Ave. City

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/6/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1212 St. Paul St. Baltimore, Md.

4 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1945, at 9:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1945 to July 2nd 1945, and that I last saw him alive on July 2nd 1945.

	Duration
Immediate cause of death: Cardio-respiratory Failure	1 day
Due to: Bronchopneumonia, Rt. L.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 7/2/45 M.D.

VS 150

X

G30117 — BALTIMORE CITY HEALTH DEPARTMENT — G30117 Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Ridgely St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert Sohnell

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1862

8. AGE: Years 82 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Incapacitated-Lifetime
11. Industry or business

FATHER 12. Name Frederick Sohnell
FATHER 13. Birthplace Germany
MOTHER 14. Maiden Name Dora Wichman
MOTHER 15. Birthplace Germany

16 (a) Informant Mrs. Emma Eckhardt
(b) Address 937 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St. Balto., Md.

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/6 1945 to 7/3 1945 and that I last saw him alive on 7/3 1945

Immediate cause of death: Acute Cardiac Failure — Duration 1 da
Due to: Hardened Arteries
Due to: Chronic Cardiac Nephritis, Prostatic Cancer
Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G Lawlach M. D.
Address 1 E Wallington Blvd Date signed 7/3/45

Filed Jul 6 1945 Huntington Williams Registrar

G30118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Potts

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 577-16-3851

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lyle L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1891
8. AGE: Years 53 | Months 5 10 | Days 17 | If less than one day hr. min.
9. Birthplace Hancock, Md.
(Town, county, and state)
10. Usual Occupation Pipe Fitter
11. Industry or business Md. Drydock

FATHER
12. Name Jack Potts
13. Birthplace Hancock Md.

MOTHER
14. Maiden Name Lena Tanner
15. Birthplace Hancock Md.

16 (a) Informant Lyle Potts
(b) Address 500 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)
(c) Cemetery or crematory National
Location Balto., Maryland

18 (a) Funeral director Williams, Cook Inc.
(b) Address 1217 E. Fayette Street

19 (a) 1945 (Date filed by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 3 10 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Graham M.D.
Medical Examiner
Date signed July 3rd 1945

Huntington Hotchkiss, M.D.

G30119
T.N. 89061

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30119
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 month & 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 W. Fairmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Seegar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 70			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William C. Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmena Hermon
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (b) Date thereof July 4/45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. D. WIPPERT & SON
(b) Address 1300 Eastern Ave

19 (a) July 4 - 1945 (b) (Date rec'd by Registrar) Registrar

Chartered for Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944 to July 1st 1945, and that I last saw her alive on July 1st 1945.

	Duration
Immediate cause of death Congestive heart failure	2 hrs
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Diabetes Mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7-5-45

93D

G30150 ✓ G30150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mt. Clare "B" Yards
(c) Hospital or institution Near Pulaski St Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur E. Dowell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 26-1943

8. AGE: Years	Months	Days	If less than one day
1	10	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Arthur E. Dowell.
13. Birthplace Md.

MOTHER
14. Maiden Name Ruth E. Richardson
15. Birthplace Md.

16 (a) Informant Ruth E. Dowell
(b) Address 624 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. A. Pettibone & Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by Registrar) (b) Registered No. 169

JUL 5 1945

VS 151

Hunting for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 8:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7/2/45 at 21/2 & 15p. M.

(b) Where did injury occur? Mt. Clare "B" Yards Pulaski St

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? no

(d) Means of injury Pedestrian Struck by train

23. Signature R. Earl Le Gates M.D.
Medical Examiner.

Date signed July 3rd 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WOL 85

G30121 ✓ G30121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 N. LAKEWOOD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. LAKEWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CHARLES B. SCHUTZ

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: AGNES SCHUTZ

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 7 1877

8. AGE: Years 67 | Months 6 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation ELECTRIC PLANT

11. Industry or business SURGICAL INSTRUMENTS

FATHER
12. Name WENDELIN SCHUTZ
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARGARET OTTO
15. Birthplace BALTO. MD.

16 (a) Informant AGNES SCHUTZ (WIFE)
(b) Address 502 N. LAKEWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 5/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly + Zeiler Co.
(b) Address 403 S. WOLFE ST.

19 (a) 7-1945 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 2 1945, at 8/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 7/2 1945 and that I last saw him alive on 7/2 1945.

Immediate cause of death: Carcinoma of Stomach — 1 Dem.

Due to:

Due to:

Other Conditions: Low Blood Pressure

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: X

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? X
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? +
(Specify type of place)
(e) Means of injury X

23. Signature C. L. O'Hearn, M. D.
Address 3901 Fairmount Blvd. 7/7/45
X

BALTIMORE CITY HEALTH DEPARTMENT

G30122 CERTIFICATE OF DEATH 94a Registered No. G30122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Chas Caudle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Strutt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name ?

13. Birthplace Ga.

MOTHER 14. Maiden Name ?

15. Birthplace Ga.

16 (a) Informant W. T. Harrison, Jr.

(b) Address Lakeland, Fla. - Route #4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/45 (month) (day) (year)

(c) Cemetery or crematory Socrum

Location Lakeland, Fla.

18 (a) Funeral director John O Mitchell

(b) Address 1900 Eutaw Pl.

19 (a) 1945 (b) Filed by registrar Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 45 19, at 1A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Mueller M.D. Medical Examiner.
Date signed July 1, 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

G30123 ✓ G30123

TN. 93506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1201 Argyle Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Sept.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8th, 1913

8. AGE: Years	Months	Days	If less than one day
31	9	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Frank Harris (D

13. Birthplace Maryland

MOTHER

14. Maiden Name Emily Thompson

15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)

(c) Cemetery or crematory St Lukes Cem

Location Reisterstown Balto Co.

18 (a) Funeral director Mr. Frances A. Hemsley

(b) Address 578 N. Biddle St

(a) (Date received) JUL 4 1945 (Registrar) Huntington Williams M.D. (Deputy)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945 at 9.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7th, 1945 to July 1st 1945 and that I last saw him alive on July 1st 1945

Immediate cause of death	Duration
Hypostatic pneumonia	46 hrs.
Uremia	3 days
Due to	
Due to	
Other Conditions 1. Non-specific colitis 2 Perirectal abscess	1 - 2 wks 2. - 1 yr.

(Include pregnancy within 3 months of death)

Date of operation 6-18-45

Major findings of operation: Non-specific colitis

of autopsy: Report not complete

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas J. O'Neill M. D.

Address Baltimore City Hospitals Date signed 7-3-45

X

G30124 ✓ G30124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada Skates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife May 21 1890

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55	1	13	hr. min.

9. Birthplace Red House Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Scott
13. Birthplace Va

MOTHER
14. Maiden Name Scott
15. Birthplace Va

16 (a) Informant Wiley Skates.
(b) Address 1037 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-45 (month) (day) (year)

(c) Cemetery or crematory
Location Lynchburg Va

18 (a) Funeral Mrs Amanda Kemly
(b) Address 578 N Bidale St

19 (a) 1945 (b) (Date rec'd by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3 1945 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1945 to 7/3 1945 and that I last saw alive on 7/2 1945.

Immediate cause of death	Duration
Cerebral apoplexy	
Due to * Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B M R Willis M. D.

Address 1134 Druid Hill Ave Date signed 7/5/45

VS 150

G30125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G30125
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 W Fayette St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 1yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1203 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaacus O. Johnson

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Chief Pharmacist Navy

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Carrie Barr
(b) Address 1203 W. Fayette St

17 (a) burial (b) Date thereof 7/5/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore National Cem.
Location 5301 Frederick Rd.

18 (a) Funeral director Tolan Gowan & Sons
(b) Address 401-03 E. Lollues St.

19 (a) 7-4-1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/1/1945, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 1945 and that I last saw him alive on July 1 1945.

Immediate cause of death	Duration
(a) Acute Cardiac Dilatation	One day
Due to (b) Cardio Vascular disease	2
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Glassman, M.D.
Address 753 W. Fayette St Date signed July 3 45

VS 150

G30426 ✓ G30426 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Whittier Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Schaumberg, Sigmund Schaumberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
65				

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER — 12. Name	
13. Birthplace	Germany
MOTHER — 14. Maiden Name	
15. Birthplace	Germany

16 (a) Informant Herbert Altenheim
(b) Address 2306 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Gor Levins Sta

18 (a) Funeral director 1439 E. Balto. St
(b) Address

19 (a) 7-4-1945 (Date received by Registrar) (b) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1945 to 7-2 1945, and that I last saw h[illegible] alive on 7-2 1945.

Immediate cause of death Coronary Occlusion — Duration

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome P. Harlow M. D.
Address Sinai Hospital Date signed 7-3-45

G30127 ✓ G30127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1225

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Manhattan
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Wm. Rubenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-45

8. AGE: Years | Months: 3 | Days: 23 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Hyman Rubenstein
13. Birthplace Md

MOTHER
14. Maiden Name Rena Blaustein
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-45 (month) (day) (year)
(c) Cemetery or crematory Sinai Israel Cong
Location Pimlico Avenue

18 (a) Funeral director Jacob Weinberg
(b) Address 1945 E. Balto St. Attending for Baltimore, Md.

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945 at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 45 to July 3 1945 and that I last saw him alive on July 3 1945

Immediate cause of death: Intestinal Obstruction — Duration: 2 wks

Due to: Hirschsprung's Disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Romona A. Hall Asst Rec
Address Hopkins Hospital Date signed 7-3-45

X

VS 150

G30428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G30428 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7013 Liberty Heights
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Scott st (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah E Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 7 1867

8. AGE: Years 78 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Christopher Gilespie
13. Birthplace Ohio

MOTHER
14. Maiden Name Sally Burns
15. Birthplace Oregon

16 (a) Informant Lillian E Jones
(b) Address 1128 Scott st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-5-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) (Date) (Registrar) Huntington Williams, M.D. (Registrar)
3-4-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2/45 19 , at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 19 45 to 7/2 19 45 ; and that I last saw h alive on 4/2 19 45 .

Immediate cause of death: Hypostatic Pneumonia — Duration 24 hrs.

Due to: Senility — 3 yrs

Due to: Generalized Arteria Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Joseph A Jones (Attending)
Address 1128 Scott st Date signed 3/3/45

G30429 ✓ G30429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 343 S. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Bartels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva E. (Lambert)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1865.

8. AGE: Years	Months	Days	If less than one day
79	10	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Henry Bartels
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Eva E. Bartels
(b) Address 343 S. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/45. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.
18 (a) Funeral director Harry H. Lutzke
(b) Address 4101 Edmondson Ave.
19 (a) Date rec'd by registrar Huntington Williams M.D. Registrar
JUL 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 9 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944 to July 2 1945 and that I last saw h alive on June 30 45
Immediate cause of death Cancer of Tongue and Throat — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None
23. Signature John A. Oram M. D.
Address 6 E Mt Vernon Pl Date signed

X

G30430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G30430 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2509 Calverton Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2509 Calverton Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Koontz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Koontz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1882.

8. AGE: Years	Months	Days	If less than one day
62	11	28	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Edward Koontz
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah E. Liskey
15. Birthplace Va.

16 (a) Informant Mrs. Anna E. Koontz
(b) Address 2509 Calverton Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/45. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Kuhtic
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

JUL 4-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to 7-1 1945 and that I last saw him alive on 7-1 1945.

Immediate cause of death Bronchio pneumonia — Duration 5 days
Due to Carcinoma of larynx
Due to Inoperable
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 4/12-45
Major findings of operation: Tumefaction
of autopsy: TRACHEOTOMY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Fred J. Lyons M. D.
Address Medical Arts Bldg Date signed 7-2-45

X

G30131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

✓ G30131 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County Brooklyn
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3429 Sixth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Kesterson

3 (b) If veteran, name war

3 (c) Social Security Account No. 440-10-0338

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gladys L. Kesterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7-1910

8. AGE: Years	Months	Days	If less than one day
34	11	26	hr. min.

9. Birthplace Kentuckey
(Town, county, and state)
10. Usual Occupation Mngr. Tobacco Service Sta.
11. Industry or business

FATHER
12. Name Harry Kesterson
13. Birthplace Kentuckey

MOTHER
14. Maiden Name Emma Welch
15. Birthplace Oklahoma

16 (a) Informant Mrs Robert J. Kesterson
(b) Address 3429 Sixth St (25)

17 (a) Burial (b) Date thereof July 7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairlawn Cem
Location Oklahoma City - Oklahoma

18 (a) Funeral director Milton Schilling Jr
(b) Address 3914 S. Hanover St

19 (a) 1945 (b) Huntington, West Virginia
Date received by registrar (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7-1945 at 4 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lio death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Ruptured liver
Multiple fractures, lacerations etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-3-45 at a.a. tec. 3:45 A.M.
(b) Where did injury occur? Litchie Highway nr. Lio
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Passenger in auto - went into parked auto

23. Signature Horace J. Walker M.D.
Medical Examiner
Date signed 7-3-45

VS 151

356005 30132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. 30432

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Montford (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph King
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27-1887

8. AGE: Years 57 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Shucker
11. Industry or business

FATHER 12. Name John King
13. Birthplace Md -

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant JOHN Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Gelali Rd.

18 (a) Funeral director John L. Miller
(b) Address 1045 E 34 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 1 1945 and that I last saw deceased alive on July 1 1945

Immediate cause of death pulmonary edema — Duration
Due to syphilitic aortic insufficiency
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hobson A. Vance
Address Johns Hopkins Hospital Signed 7/3/45

G30433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G30433 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Baker St
(c) Hospital or institution: 1516

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriet M. Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas C. Pryor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 7 1857

8. AGE: Years 87 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob Swope
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Huntsberry
15. Birthplace Md

16 (a) Informant K. Pearl Jones
(b) Address 2727 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Smithburg Maryland

18 (a) Funeral director Pratt C. B. M. Walters
(b) Address Pratt & Stricker Sts

19 (Date rec'd by registrar) July 4 1945 Registrar Arlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 806 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to July 1 1945 and that I last saw her alive on June 29 1945

Immediate cause of death
1 Carcinomatosis of Bladder

Due to

Due to

Other Conditions Senility - Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:

of autopsy: None

Duration: 6 months

?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts Date signed 7/3/45

VS 180

G30434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

G30434
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3338 Chestnut Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3338 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred I. Harding.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Oscar L. Harding
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) July 11, 1913

8. AGE: Years 31 | Months 11 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Leshure
13. Birthplace Maryland.

MOTHER
14. Maiden Name Irene O'Connor
15. Birthplace Maryland.

16 (a) Informant Oscar L. Harding
(b) Address 3338 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hyattsville

18 (a) Funeral director Chenault & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (b)
(Date) (Registrar) Huntington Williamson, M.D.

JUL 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1943 to July 2 1945, and that I last saw h[illegible] alive on July 2 1945

Immediate cause of death	Duration
Rheumatic Heart Disease	
Due to Heart Failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wallenstein M.D.
Address 878 W 36th St Date signed July 4/45

G30135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G30135

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 58 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 Willow ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabel B. Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Wm J Redmond
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 24-1907

8. AGE: Years	Months	Days	If less than one day
41	1a	10	hr. min.

9. Birthplace Woodbine York Co Pa
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name George W Flaherty
13. Birthplace Woodbine Pa

MOTHER
14. Maiden Name Emaline Howard
15. Birthplace Woodbine Pa

16 (a) Informant Wm J Redmond
(b) Address 237 Willow ave Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6-45 (month) (day) (year)
(c) Cemetery or crematory United Presbyterian
Location Airville York Co Pa

18 (a) Funeral director Martin E Hunt
(b) Address Jarrettsville Md.

19 JUL 5 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4 1945, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6- 1945 to 7-4 1945, and that I last saw her alive on 7-4 1945

Immediate cause of death: Respiratory Failure — Duration:
Due to:
Due to: Carcinoma Sigmoid
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Raleestown M. D.
Address St. Joseph's Hosp Date signed 7-4-45

VS 150

G30436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G30436

Registered No. 60958

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important: Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo. 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Cedar Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Zupicich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1890

8. AGE: Years	Months	Days	If less than one day
55		10	hr. min.

9. Birthplace Austria ?
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business U.S. Eng. Corps

FATHER
12. Name Domonick Zupicich
13. Birthplace Austria

MOTHER
14. Maiden Name Antonia ?
15. Birthplace Austria

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (b) Date thereof July 4 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shamokin
Location Pennsylvania

18 (a) Funeral director W. J. Lichner & Sons
(b) Address Mt. Penna. Ave., Balto, Md.,

19 (a) JUL 5 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 3 1945, at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1945, to July 3 1945, and that I last saw him alive on July 3 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to — Sev. yrs

Due to

Other Conditions Benign hypertrophy of prostate. Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation May 31, 1945

Major findings of operation: Perineal prostectomy

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.

Address U. S. Marine Hospital Date signed 7/4/45

Baltimore 11, Maryland

G30437

475409

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 66 B

G30437.
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Hanover. (If outside city or town limits, write RURAL and give town)
(d) Street No. 283 Third St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Ellen Myers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Charles Lester Myers
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 3-22-04

8. AGE: Years	Months	Days	If less than one day
41	3	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Home: wife
11. Industry or business

FATHER
12. Name Jacob R Hersom.
13. Birthplace ? ? Md.

MOTHER
14. Maiden Name Ida E. Bemiller
15. Birthplace ? ? Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal. (Burial, cremation, or removal) (b) Date thereof July 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Hanover.
Location Hanover.

18 (a) Funeral director W. A. Fleagle
(b) Address Hanover Pa.

19 (a) JUL 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945. at 4.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945. to July 4 1945. and that I last saw her alive on July 4 1945.

Immediate cause of death: Obstruction - Obstruction Disease. Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death.)

Date of operation 6/14 & 6/18/45

Major findings of operation: Lesions in Small

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul W. Chambers
Address Johns Hopkins Hosp. Date signed 7/4/45
Balto. Md. X

VS 150

G30438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

G30438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Baker St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Mollie Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
— —	None	F.	Col.	Widow

6 (b) Name of husband or wife Addision Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16

8. AGE: Years	Months	Days	If less than one day hr.	min.
61	-	15		

9. Birthplace Calvert County Md.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Thomas Jefferson
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Elizabeth Graham
15. Birthplace Calvert Co. Md.

16 (a) Informant Ruth C. Graeen
(b) Address 411 N. Belvedere St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Balto, Maryland

18 (a) Funeral director Archibald P. Gaddis
(b) Address 2101 McCulloh St.

19 JUL 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to June 30 1945, and that I last saw her alive on June 30 1945.

	Duration
Immediate cause of death Heat Stroke	
Due to Excessive Heat	3 days.
Due to	
Other Conditions Incontinence Urine	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Mansell Lawrence M. D.
Address 1033 W. Lanvale Date signed 7/3/45

VS 3

G30439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30439

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N 34 St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C Treahmann

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22. 1862

8. AGE: Years	Months	Days	If less than one day
83	1	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Clothing Cutter

11. Industry or business

FATHER
12. Name Sebastian Treahmann
13. Birthplace Germany

MOTHER
14. Maiden Name Anna K Bunk
15. Birthplace Germany

16 (a) Informant John C Treahmann
(b) Address 817 Wellington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 1945 N 36th St.

19 JUL 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945 at 705 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to July 2 1945 and that I last saw h[illegible] alive on July 1 1945

Immediate cause of death Heart Failure
Interventricular
Due to Heart Disease
Due to Cerebral Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
20 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wallenstein M.D.
Address 1945 N 36th St Date signed 7/5/45

VS 189

G30440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G30440
Registered No.

AB-93952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27- 1894

8. AGE: Years	Months	Days	If less than one day
51	2	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peton Johnson
13. Birthplace ?

MOTHER
14. Maiden Name Annie
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 5 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20- 1945, at 3.30p M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1945, to 6-20 1945, and that I last saw him alive on 6-20- 1945.

Immediate cause of death Bronchopneumonia

Duration 7

Due to acute mastoid organs

Due to

Other Conditions arteriosclerosis, Renal and Cerebral ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. M. Phillips M.D.
Address Baltimore, Md. Date signed 6-28-45

2806

VS 100

G30141

REP -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87C ✓ Registered No. G30141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4-20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Colbert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1888

8. AGE: Years	Months	Days	If less than one day
57	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lemuel or Samuel
13. Birthplace ? Md.

MOTHER
14. Maiden Name Georgianna Owens
15. Birthplace ? Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1945, at 3:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1936 to June 17, 1945, and that I last saw h im alive on June 17, 1945.

Immediate cause of death a Paralysis agitans
Due to
Due to
Other Conditions Arteriosclerosis, Dementia Cerebral
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Yes

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 7-5-45

(1807)

VS 150

G30142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G30142

JO #61864

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs. 6mos. 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Bernard Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1877

8. AGE: Years	Months	Days	If less than one day
68	5	9	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Odd Jobs
11. Industry or business

FATHER
12. Name David Anderson (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Rachel Homes
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 5 1945 (Date rec'd by registrar) Waiting for Milligan's R.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1945 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15, 1940 to June 21, 1945, and that I last saw h im alive on June 20, 1945.

Immediate cause of death	Duration
	?
Due to	
Due to	?
Other Conditions Arteriosclerosis, Generalized Cerebral (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. Philpp M. D.
Address Balt City Hosp Date signed 6-28-45

VS 150

2808

G30443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G30443
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3329 Gwynns Falls Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3329 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION ODELLA SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Charles Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 18[illegible]

8. AGE: Years	Months	Days	If less than one day
61	8	15	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Tilghman C. Isaac
13. Birthplace Davidsonville, Md.

MOTHER
14. Maiden Name Amelia A. Ward
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Tilghman C. Isaac
(b) Address 3329 Gwynns Falls Pkwy

17 (a) Burial (b) Date thereof 7/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
rec'd by reg. JUL 5 - 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945 to July 2 1945 and that I last saw her alive on July 1 1945

Immediate cause of death Carcinoma of Lung Left — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address July 5 [illegible] Date signed 194[illegible]

G30144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G30144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Brentwood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Brentwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	married

6 (b) Name of husband or wife Olivia Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75 74	-		hr. min.

9. Birthplace A. A. Co. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Olivia Brown
(b) Address 2428 Brentwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Davis
(b) Address 142 W. Hoed St Huntington Williamson, W. Va.

JUL 5 - 1945
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 1 am M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to July 2 1945 and that I last saw h alive on July 2 1945.

Immediate cause of death Cardio-renal Disease — Duration 2 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis A. Jolesman M. D.
Address 2329 Greenmount Ave Date signed July 6 1945

VS 150

G30445

BALTIMORE CITY HEALTH DEPARTMENT ✓ G30445

CERTIFICATE OF DEATH 93

Registered No. (No.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S. Sharp Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Au Gusta Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER 12. Name —

13. Birthplace

MOTHER 14. Maiden Name Jane Watkins

15. Birthplace Md

16 (a) Informant Maud Knox

(b) Address 624 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director James A. Hayes

(b) Address 142 W. Hill St.

19 (a) JUL 5 1945 (Date received by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 8 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Arteriosclerotic Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed July 2nd 1945

VS 151

G30446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G30446

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE W. EATON

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James P. Eaton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1866

8. AGE: Years 78 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Dorchester Co., Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William J. Wheeler
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth A. Spedden
15. Birthplace Md.

16 (a) Informant Mr. William P. ~~Spedden~~ Eaton
(b) Address 1003 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 7/5/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 5 1945 **(b)** Registered by registrar
Funeral for Williamsburg Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 1:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to July 1 1945 and that I last saw her alive on July 1 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 wk
Due to Arterio-sclerosis Hypertension — Duration Indef
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. W. Leady
Address 1403 Parkside Dr. Date signed 7/5/45

VS 180

(OVER)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30147 ✓ G30147 Registered No. 13 a

G30147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 Halcyon ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Halcyon ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Strickler

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Irvin Strickler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	2	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Irvin Strickler
(b) Address 2603 Halcyon Ave.

17 (a) Burial (b) Date thereof 7/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUL 5 1945 (b)
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-1945 at 5 P. M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiovascular Renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury?

23. Signature Thomas J. Mercer M.D.
Medical Examiner.
Date signed 7-3-45

G30448 26

BALTIMORE CITY HEALTH DEPARTMENT X V G30448

Registered No.

CERTIFICATE OF DEATH 1579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Glendale (If outside city or town limits, write RURAL and give town)
(d) Street No. 7304 Glenwall Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thomas Howell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/42

8. AGE: Years	Months	Days	If less than one day
2	10		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lawrence Howell
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Alice Everetta
15. Birthplace Pennsylvania

16 (a) Informant JOHNS HOPKINS HOSPITAL records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 5 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Rural

18 (a) Funeral director Ellicott Funeral Home
(b) Address 2004-8 Orleans St

19 (a) (Date) JUL 5 1945 (b) by registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1942 to 7-2 1945 and that I last saw h alive on July 2 1945

Immediate cause of death	Duration
Malnutrition & Pneumonia	
Due to Tracheo Oesophageal Fistula	2½ yrs
Due to Oesophageal Atresia	
Other Conditions Surgical Repair & Above	2½ yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena A Hall Asst Res
Address Hopkins Hospital Date signed X 7-2-45

G30449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

192

G30449
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REASON ASSIGNED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Mount Pleasant
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE A. BROWN

(Lawrence A. Brown)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd. 1932

8. AGE: Years	Months	Days	If less than one day
13	0	0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business

FATHER
12. Name Lawrence F. Brown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Trabis
15. Birthplace Balto. Md.

16 (a) Informant Lawrence F. Brown
(b) Address 3507 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Mem. Pk.
Location Glen Burnie, Md.

18 (a) Funeral director Philip Harris & Sons
(b) Address 2024 Orleans St.

19 (a) Date rec'd by Local Registrar JUL 9 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21/45 19 , at 4.10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution due to Lightning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/21/45 at 3:30 P.M. 1/3
(b) Where did injury occur? Patterson Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? No
(d) Means of injury Lightning

23. Signature John R. Travis, M.D.
Medical Examiner.
Date signed 7/23/45

G30450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G30450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rukeland & Raynar

(c) Hospital or institution: West Baltimore Gneral Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimd (If outside city or town limits, write RURAL and give town)

(d) Street No. 2522 Mc Elderry St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emary E. Lynch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John Lynch (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1871

8. AGE: Years	Months	Days	If less than one day
73	11	4	hr. min.

9. Birthplace Baltimd (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Childs

13. Birthplace Baltimd

MOTHER 14. Maiden Name — Hickman

15. Birthplace Baltimd

16 (a) Informant John N. Lynch

(b) Address 2600 Munde St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7/45 (month) (day) (year)

(c) Cemetery or crematory Baltimd

Location Baltimd

18 (a) Funeral director Philip Herwig Sons

(b) Address 2124 Veleans St

19 (a) (Signature of registrar) (b) Registrar

JUL 5 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 5 29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945 to July 3 1945, and that I last saw h e l alive on July 3 1945.

Immediate cause of death Pulmonary Lymphangitis

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Baltimore

Address West Baltimore Gneral Hosp. Date signed 7/2/45 M.D.

X

G30451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

✓ G30451 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK T. PANICCIA
or Francesco Panice

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-1965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Stel.Co.Sparrows

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Achille Danunzio (Husband)
(b) Address 123 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5th/45 (month) (day) (year)
(c) Cemetery xxxxxxx Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (Date received by registrar) JUL 5 1945 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 12:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Point
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-24-45 at 2:00 A. M.
(b) Where did injury occur? In front of 108 Jackson Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Struck on head

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 2nd 1945

X

G30152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

G30152

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... President Hospital
(c) Hospital or institution: 1514 Riviera Ct
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Edmondson
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rena L. Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	none	F	col	Married

6 (b) Name of husband or wife Rob't Johnson (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 8-25-1902

8. AGE: Years	Months	Days	If less than one day
42	10	7	hr. ..... min.

9. Birthplace Washington D.C. (Town, county and state)
10. Usual Occupation School teacher
11. Industry or business Balto. City Dept. Ed.

FATHER
12. Name Arthur
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Rosa Lee
15. Birthplace Wash. D.C.

16 (a) Informant Robt Johnson
(b) Address 1507 Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-1945 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Washington D.C.

18 (a) Funeral director Sharp & Cooper
(b) Address 572 N. Carrollton Av.

19 (a) [illegible] Washington Williams MD
(Name recd by registrar) JUL 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-1945, at 2:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27-1945 to 7-2-1945 and that I last saw deceased alive on 7-2-1945.

Immediate cause of death Coronary Embolism — Duration 5 days

Due to Coronary Sclerosis

Due to Extensively Sclerosed Coronary Arteries — Duration over

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation 6-28-1945

Major findings of operation: Enlarged

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature M Eusha M. D.
Address 803 N. Fremont Ave. Date signed .....

G30453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30453 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mary Hunter

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: ~~Separated~~

6 (b) Name of husband or ~~wife~~: Mosley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1896

8. AGE: Years 48 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Thomas Bowler
13. Birthplace Va.

MOTHER
14. Maiden Name Julia
15. Birthplace Va.

16 (a) Informant Nathaniel Bowler
(b) Address 1200 St. James St. Richmond Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory Hanover
Location Hanover Co. Va.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (Date rec'd by registrar) (b) Huntington Nathaniel M.D. Registrar

VS JUL 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1945 at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to July 3 1945 and that I last saw her alive on July 3 1945.

Immediate cause of death: Cardio Vascular Disease — Duration: Aug 1944
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 515 N. Arlington Ave Date signed 7/5/45

X

G30454 55 Mill 2220 Garrison Blvd Li 7600 ✓

BALTIMORE CITY HEALTH DEPARTMENT X 937 ✓ Registered No. G30454

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Manner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Eulalia Manner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3rd 1867

8. AGE: Years	Months	Days	If less than one day
77	10	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Tailor.

FATHER
12. Name Robert Manner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kellerman
15. Birthplace Germany

16 (a) Informant Harry Manner
(b) Address 1609 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery ~~co-operative~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 7/5 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 1945, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1945 to July 4 1945, and that I last saw him alive on July 3 1945.

Immediate cause of death	Duration
Myocarditis	2 mo
Due to	
Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dubbell M. D.
Address 2220 Garrison Date signed

VS 150

X Dated July 3/45

G30455

JL - 94361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G30455 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Currier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1890

8. AGE: Years	Months	Days	If less than one day
54	6	5	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Currier
13. Birthplace Pa.

MOTHER
14. Maiden Name Annie MARTINOW.
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Milburn Oak Day
(b) Address 214 N. Gay St.

19 (a) JUL 5 - 1945 (b) Huntington Williams, Md.
(Date received by local registrar) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945, to July 4 1945, and that I last saw him alive on July 4 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of lung, far advanced	1 yr.
Due to	
Other Conditions Urinary retention	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hospitals Date signed 7-4-45

G30456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3926 Pennington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3926 Pennington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE JEFFERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of ~~husband~~ or wife Elizabeth Dance

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29th 1897

8. AGE: Years 47 45 | Months 11 10 | Days 27 4 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Pipe-fitter

11. Industry or business U.S. Coast Guard Depot

FATHER 12. Name Wm. Jefferson

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Matilda Roberts

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Elizabeth Jefferson

(b) Address 3926 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/45 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Howard Co.

18 (a) Funeral director C. I. Gormley & Son

(b) Address 1938 E. Lafayette Ave.

19 (a) Filed (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/45 19 , at 9 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.

Date signed 7/3/45

G30457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30457

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hosp 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 112 N. Fremont Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME TAKEF, Milton

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER

12. Name Reuben

13. Birthplace Latvia

MOTHER

14. Maiden Name Bleyma

15. Birthplace Latvia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)

(c) Cemetery or crematory Balto Hebrew

Location Belair Rd

18 (a) Funeral director Jos Lewis Inc

(b) Address 1439 E. Balt St

19 (a) JUL 5 1945 (Date rec'd by Registrar)

Running for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4 1945 at 4 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 7-4 1945 and that I last saw him alive on 7-4 1945.

Immediate cause of death Cerebral hemorrhage left

Due to Hypertension and Arteriosclerotic CV Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: chronic pyelonephritis left + Mt above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Irene P. Durkin M. D.

Sinai Hospital

Date signed 7-4-45

X

G30458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G30458

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Federal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Tinsley (TINSLET)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Elizabeth Tinsley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1874

8. AGE: Years	Months	Days	If less than one day
70	10	7	hr. min.

9. Birthplace Richmond, Va. (City, county, and state)
10. Usual Occupation Porter
11. Industry or business

MOTHER / FATHER
12. Name Richard Tinsley
13. Birthplace Richmond, Va.
14. Maiden Name Ellen Appleton
15. Birthplace Richmond, Va.

16 (a) Informant Elizabeth Tinsley
(b) Address 406 Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. Law. Id. Hall
(b) Address 1631 Druid Hill Ave.

19 (a) July 5 1945 (Date received by registrar) (b) Huntington-Williams M.R.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 2 1945, and that I last saw him alive on July 1 1945

Immediate cause of death	Duration
Diabetes	
Due to gangrene of Foot	
Due to Septicemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Rhoads M. D.
Address 1324 Druid Hill Ave Date signed July 2 1945

G30459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G30459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Montebello Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Gray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Lorena Gray
6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) May 30, 1864

8. AGE: Years	Months	Days	If less than one day
81	9	2	hr. min.

9. Birthplace Hanover Md.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Stephen C. Gray
(b) Address 2401 Montebello Terrace

17 (a) Burial (b) Date thereof 7-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JUL 5 1945 (b) Huntington Williams, Mgr
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to July 1 1945, and that I last saw him alive on July 1 1945.

Immediate cause of death	Duration
Cardio Vascular Disease	1 yr.
Due to Arthritis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Fray
Address 938 Penna Ave Date signed 7/3/45
(M.D.)

X

G30460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G30460
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 N. Gilmor St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Granville Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1893

8. AGE: Years: 52 | Months: 1 | Days: 22 | If less than one day: hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bowman
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Snowden
15. Birthplace Howard County Md.

16 (a) Informant Virgie Hawkins
(b) Address 421 N. Gilmor St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Auburn

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Saberooden St.

JUL 5-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1943 to 7-1 1945.
and that I last saw h.[illegible] alive on 7-1 1945.

Immediate cause of death Uremia — Duration 2 months
Due to Hypertension
Due to Cerebral Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Percy W. Redding Jr.
Address 426 W. Lafayette Ave. Date signed 7/3/45

G30461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G30461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 N. Bethel st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605, N. Bethel st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilm[redacted] Thompson

3 (b) If veteran, name war: First World War
3 (c) Social Security Account No. 214-10-0205

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola Thompson
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Oliver Jerome Thompson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Krista V. Saunder
15. Birthplace Baltimore, Md.

16 (a) Informant Viola Thompson
(b) Address 605 N. Bethel st.

17 (a) [redacted] Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1945 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Baltimore, Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421, E. Jefferson st.

19 (a) JUL 5 1945 (date received by registrar) (b) Huntington Williams, M.D. Registrar

WS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-45 19..., at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30-45 19..., to 7-2-45 19..., and that I last saw him alive on 7-2-45 19...

Immediate cause of death	Duration
Acute Dilatation of the Heart	Suddenly
Due to Rob[illegible] Pneumonia	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maury Adams M. D.
Address 312 E. 23rd st Date signed 7-3-45

G30462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G30462 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 S. Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Brantner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Emma C. BRANTNER
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	3	hr. min.

9. Birthplace Martinsburg, W.Va.
(Town, county, and state)
10. Usual Occupation boiler Maker
11. Industry or business B. & O. R.R.

FATHER
12. Name Frisby Brantner
13. Birthplace Boonsboro, Md.

MOTHER
14. Maiden Name Mary Bodha
15. Birthplace Sandy Hook, Md.

16 (a) Informant Emma C. Brantner
(b) Address 310 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Coles
(b) Address 1200 W. Lombard St

19 (a) [illegible] 1945 Huntington Williams, M.D.
(Registrar)

YS 180

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH July 2nd, 1945, at 8:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 30 1945 to July 2 1945, and that I last saw h[illegible] alive on July 1 1945.

	Duration
Immediate cause of death: Carcinoma of Head	4 mos
Due to: Cancerous	
Due to: Malignant	✓
Due to: Cachexia	
Other Conditions: ✓	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Edwin A. Woodward M.D.
Address 1219 Eutaw Place Date signed 7/4/45.

G30463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X-54 B

G30463

Registered No. 61860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Portland (If outside city or town limits, write RURAL and give town)
(d) Street No. 5631 N. E. 25th Avenue (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Owen Joseph McNamara

3 (b) If veteran, name war

3 (c) Social Security Account No. 545-20-3093

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Greal
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	5	hr. min.

9. Birthplace Nevada Co., California (Town, county, and state)
10. Usual Occupation Deck engineer
11. Industry or business Seafaring

FATHER
12. Name James McNamara
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Murphy
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Loving Perpetuain
Location York Rd

18 (a) Funeral director R. Lee Ader
(b) Address 4644 York Rd.

19 (a) [illegible] by [illegible] Washington Boulevard

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 2, 1945, at 6:50 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to July 2 1945, and that I last saw him alive on July 2 1945.

	Duration
Immediate cause of death Neuroblastoma involving base of neck mediastinum, right lung and retro-	3 months
Due to peritoneal space.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/3/45

Baltimore 11, Maryland. X

G30464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30464 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address V-823 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. V-823 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES EARL KIRBY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	

6 (b) Name of husband or wife Sarah E. Kirby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-1890

8. AGE: Years	Months	Days	If less than one day
55	3	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Martin Luther Kirby
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rose Mechalske
15. Birthplace Baltimore Md

16 (a) Informant Mrs Sarah E. Kirby
(b) Address V-823 Belair Rd

17 (a) Burial (b) Date thereof 7-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Wendell E. Humphreys
(b) Address 1401 N. Broadway

19 (a) (Date rec'd by registrar) (b) Registered

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2- 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1945 to July 2 1945 and that I last saw h alive on July 2, 45

Immediate cause of death

	Duration
Uremia Glomerulonephritis	-
Due to Coronary Sclerosis	
Due to	
Other Conditions Bronchial Asthma	4 mos 2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Mayer M. D.
Address 516 Cathedral Date signed 7-3-45

X

G30465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

Registered No. G30465

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1. E. Randall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl O'Keefe

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-45

8. AGE: Years | Months | Days | If less than one day 2 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business none

FATHER
12. Name Henry O'Keefe
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Hilda O'Keefe
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 1 E Randall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7/6/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md
18 (a) Funeral director J. B. Lilly
(b) Address 130 E. Fort Ave.
19 (a) (Signature of registrar) Huntington Williams, M.D. Registrar
(b) Date received JUL 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1945 to 7-4 1945, and that I last saw her alive on 7-4 1945

Immediate cause of death	Duration
Respiratory failure	
Due to	
Due to	
Other Conditions Meningiocoele (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Meningiocoele

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby T. Evans M. D.
Address Franklin Sq. Hosp. Date signed 7-5-45

G30466
474489.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 1190

Registered No. G30466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5/4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Balto Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Davis. (Patricia)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-26-45

8. AGE: Years | Months: 5 weeks | Days | If less than one day: hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Davis
13. Birthplace Conn.

MOTHER
14. Maiden Name Agnes Wa Great.
15. Birthplace Conn.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location paltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 5 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 4. 1945, at 5.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May. 26 1945. to July. 4th 1945, and that I last saw h alive on July. 4 - 1945.

Immediate cause of death	Duration
Prematurity	
Due to Diarrhea	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena A. Hall asst Res
Address Hopkins Hospital Date signed 7-4-45

X

G30467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

152

Registered No. G30467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or Institution: So. Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Millers Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Novak Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-25-37

8. AGE: Years	Months	Days	If less than one day: hr.	min.
8	4	7		

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Novak Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Daugherty
15. Birthplace Baltimore

16 (a) Informant James Novak Sr
(b) Address Millersville Md

17 (a) Burial (b) Date thereof 7-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Md

18 (a) Funeral director Mark Cavanaugh Sons
(b) Address 800 N. Charles St

19 (a) Registered JUL 5 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1945 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 7-3 1945 and that I last saw him alive on 7-3 1945

Immediate cause of death	Duration
Septicemia	
Due to Multiple abscess	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Cavanaugh
Address 1213 Light St Date signed 7-5-45

VS 130

G30468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G30468 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 E. Barney St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E. Barney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Stenger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Kathryn Stenger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1876

8. AGE: Years 69 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation Glass blower (retired)

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Phillip J. Stenger
(b) Address 124 E. Barney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Wenkus Inc.
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington W. Va. (Signature)

MAR 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to July 2 1945 and that I last saw him alive on 6/29 1945.

Immediate cause of death

Due to

Due to Bronchial pneumonia

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leopold Quinn M. D.
Address 203 Belgrano St. Date signed

G30469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G30469

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Clifton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Pt. Stall

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 215-03-2028

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: VERNA B.

6 (c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.) 6/9/88

8. AGE: Years: 59 | Months: — | Days: 15 | If less than one day: hr. min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation: PHARMACIST

11. Industry or business: HEYSON-WESCOTT DONNING

FATHER
12. Name: GEORGE A. STALL
13. Birthplace: VA.

MOTHER
14. Maiden Name: CAROLINE SCHMIDT
15. Birthplace: VA.

16 (a) Informant: VERNA B. STALL
(b) Address: 2813 CLIFTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 7-7-45 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK
Location: FREDERICK AVENUE

18 (a) Funeral director: G. LESTER WEBER
(b) Address: 2503 EDMONDSON AVE.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 51 — 1545

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 9 A.M. KD

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Fetter M.D.
Medical Examiner.
Date signed July 4 1945

Hunting for Address, MD

G30470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30470 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Harford Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: md (b) County: Baltimore
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 215 Oakley Village (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME: F. Alan Ward

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife: unmarried
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-29-45

8. AGE: Years	Months	Days	If less than one day
1	7	6	..... hr. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: child
11. Industry or business

FATHER	12. Name: Geo F. Ward	Foster Parents
	13. Birthplace: Wilmington N.C	
MOTHER	14. Maiden Name: Violet Cator	
	15. Birthplace: Alexandria Va	

16 (a) Informant: Violet Cator
(b) Address: 215 Oakley Village

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK
Location: FREDERICK AVENUE

18 (a) Funeral director: C. RAYMOND KAUFMAN
(b) Address: 1026 LEEDS AVENUE

19 (a) ..... (Date received by registrar) (b) ..... (Registrar)

VS JUL 5 - 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-5 1945 at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1945 to 7-5 1945, and that I last saw him alive on 7-5 1945.

Immediate cause of death	Duration
Waterhouse-Friderichsen Syndrome	3hrs
Due to meningococcemia	12 hrs.
Due to	
Other Conditions meningococcus	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Margaret H. D. Smith M. D.
Address: Sydenham Hosp. Date signed 7-6

X

G30471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 191

Registered No. G30471

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga & Dukeland
(c) Hospital or institution West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Orem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Eckert — John Eckert

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Sophia Eckert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1873

8. AGE: Years	Months	Days	If less than one day
72	0	0	hr. min.

9. Birthplace Baltimore Co. Md. (town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Railway express Co.

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant Mrs. Stanley Bossard
(b) Address 144 Equitable Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Wilbur J. Dickey & Sons
(b) Address Arch - Baltimore Sts. Huntington Station, Md.

19 (a) (Date received by registrar) (b) Registrar

JUL 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945, to July 3 1945, and that I last saw him alive on July 2 1945.

Immediate cause of death Cerebral Edema — Duration

Due to Heat Exhaustion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Lucius W. Baldwin M. D.
Address West Baltimore Gen. Hosp. Date signed 7-3-45

VS 150

G30172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G30172

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 N. Fulton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Ronald) Donald Edward Moles

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1942

8. AGE: Years	Months	Days	If less than one day
3	5	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Robert Moles
13. Birthplace Missouri

MOTHER
14. Maiden Name Lilly M. Bichell
15. Birthplace Baltimore, Md.

16 (a) Informant John A. Hedrick, M.D.
(b) Address Mercy Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto.

18 (a) Funeral director Wm. J. Tolson & Sons
(b) Address Balto, [illegible] Williams,

(Deputy) (b) Registrar

JUL 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 4 1945 and that I last saw h[illegible] alive on July 4 1945

Immediate cause of death Cardiac failure.

Due to Congenital heart lesion causing

Due to congestive failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None 7/4/45

Major findings of operation: Congenital heart lesion

of autopsy:

Duration
Life

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John A. Hedrick
Address Mercy Hospital Date signed 7/4/45 M. D.

VS 150

G30173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30173

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Duvall Ave.
(c) Hospital or institution:
15 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Duvall Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE MUELLER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Otto Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1854

8. AGE: Years: 91 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Hanover, Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Gerhard Borcherding
13. Birthplace: Germany

MOTHER
14. Maiden Name: Marie (Unknown)
15. Birthplace: Germany

16 (a) Informant: Mrs. Catherine Wode
(b) Address: 4008 Duvall Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUL 5 1945 (Date rec'd by reg.) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 6:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to July 4 1945 and that I last saw her alive on July 3, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage & Paralysis	1 wk.
Due to Advanced Arteriosclerosis	?
Due to Hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Hallie Baker M. D.
Address 2220 Garrison Blvd Date signed 7/5/45

VS 150

G30474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G30474 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2942 Guilford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2942 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWIN VERNON COLBERT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1907

8. AGE: Years	Months	Days	If less than one day
37	9	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation –
11. Industry or business

FATHER
12. Name Edwin A. Colbert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillie Arthur
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Allan A. Colbert
(b) Address 2942 Guilford Ave.

17 (a) Burial (b) Date thereof 7/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 5 - 1945 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1938 to July 4 1945 and that I last saw him alive on July 2 1945.

Immediate cause of death Carcinoma of face with metastasis — Duration: years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Hanna M. D.
Address 205 E. Preston St. Date signed 7/5/45

VS 150

G30475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G30475 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Orlando Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Orlando Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara Riddinger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1878

8. AGE: Years	Months	Days	If less than one day
86	8	26	hr. 1858 min.

9. Birthplace Hungary (Town, county and state)
10. Usual Occupation House wife
11. Industry or business

MOTHER / FATHER
12. Name Unknown
13. Birthplace "
14. Maiden Name "
15. Birthplace "

16 (a) Informant Eugene E. Dunham
(b) Address 3012 Orlando Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6th 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport Md. (Registrar)
JUL 9 - 1945

MEDICAL CERTIFICATION 10135

20. DATE OF DEATH July 2 1945 at 0 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1945 to July 2 1945 and that I last saw her alive on July 2 1945.

Immediate cause of death	Duration
Heart failure	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Senile Marasmus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth Riddinger M. D.
Address 102 E. Fort Ave Date signed July 5 1945

X

G30476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30476

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3633 W. Belvedier ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3633 W Belvedier Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa K. Decker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Emil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Meyer Katzenberg
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Hannah
15. Birthplace Baltimore Md

16 (a) Informant Harold E. Decker
(b) Address 3633 W Belvedier ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory Chesh Memorial
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1420 N. Balto St

19 (a) (Signature of registrar) (b) Huntington Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-1945 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1944 to July 2 1945
and that I last saw h er alive on July 2 1945

Immediate cause of death: Cardiac failure — Duration: 15 minutes

Due to: Coronary Thrombosis — 2 weeks

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Cooper M.D.
Address 2401 W Lafayette Ave Date signed 7/5/45

G30477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G30477
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Schwarzkopf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1928

8. AGE: Years 16 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John C. Schwarzkopf
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie C. Rix
15. Birthplace Baltimore, Md.

16 (a) Informant John C. Schwarzkopf
(b) Address 506 N. Belnord Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 1945 (b) Date rec'd by reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 8 P. M

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-2-45 about 7:45 P.M.
(b) Where did injury occur Patterson Park Pool
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning

23. Signature Robert Lee Fentress M.D.
Medical Examiner.
Date signed July 3 1945

VS 151

G30478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

G30478

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and greene Sts
(c) Hospital or institution: Univ. of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Blair
(c) City or town Altoona
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 26th Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Elizabeth Buchanan (23)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Elmer Edward Buchanan 6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) July 24, 1899

8. AGE: Years	Months	Days	If less than one day
46	11	23	hr. min.

9. Birthplace Pittsburgh Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name George Beaty
13. Birthplace Penna.

MOTHER
14. Maiden Name [illegible]
15. Birthplace [illegible] USA

16 (a) Informant Elmer Edward Buchanan
(b) Address 4 N. Carey St, Balto

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)
(c) Cemetery or crematory Altoona Pa
Location PA

18 (a) Funeral director Robert J. Brooks
(b) Address 1330 [illegible] St.

19 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945 at 1:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1945 to July 5, 1945, and that I last saw her alive on July 5, 1945.

Immediate cause of death Cardiac failure, uremia — Duration 3 days

Due to Polycystic kidneys with uremia

Due to

Other Conditions Hypertension encephalopathy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Clark, Jr. M. D.
Address Univ. of Md. Hosp. Date signed 7/5/45

X

G30479

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30479

Registered No.

CERTIFICATE OF DEATH 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Bloomingdale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Emma Amelia Lawson

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Loyd Mahaney Lawson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1893

8. AGE: Years	Months	Days	If less than one day
51	8	17	hr. min.

9. Birthplace Connellsville, Penna
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Emma Lawson
(b) Address Catonsville

17 (a) Burial (b) Date thereof 7/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Baer St. City Md

18 (a) Funeral director Ely & Myers Nabb
(b) Address Catonsville Md

19 (Date received by registrar) JUL 6 - 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to July 3 1945, and that I last saw h. alive on July 3 1945.

Immediate cause of death	Duration
Respiratory failure, tracheal compression	
Due to Aortic aneurysm, (transverse portion)	4 yrs.
Due to Syphilis, site undetermined	
Other Conditions Bilateral hypostatic pneumonia (lower lobes)	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation tracheotomy
of autopsy: (alone)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton M. D.
Address Hosp. for Women Date signed July 3, 45
Huntington Williams, Baltimore-17, Maryland X

M. D. B. 1268-6

G30480

HEALTH DEPARTMENT—CITY OF BALTIMORE

G30480

CERTIFICATE OF DEATH

$3a

1. PLACE OF DEATH

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 700 Park avenue St., 11 - 3 Ward)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs. Amanda Boak Boyle

(a) Residence: No. 700 Park avenue St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Boyle.

6. DATE OF BIRTH (month, day, year) April 6, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. own home.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

FATHER

13. NAME George Edward Boak

14. BIRTHPLACE (city or town) (State or country) Great Britain.

MOTHER

15. MAIDEN NAME Anna M. White.

16. BIRTHPLACE (city or town) (State or country) Pennsylvania.

17. INFORMANT No Record
(Address)

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place London Park Date 7/6 19 45

19. UNDERTAKER William Cook Inc
(Address) 1217 St. Paul st

20. FILED JUL 6 1945 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 3, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 27, 1945 to July 3, 1945

last saw h[illegible] alive on July 2, 1945. Death is said to have occurred on the date stated above, at 8 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage.	not known
Other contributory causes of importance:	
Hypertension arteriosclerosis.	not known

Name of operation None. Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signature) James Graham Monsma M. D.

(Address) 516 Cathedral Street

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G30481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47C

Registered No. G30481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. 29th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William E. Hoff

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 215-10-4905

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Agnes Hoff
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) JUNE 20-1898
8. AGE: Years 47 | Months | Days 14 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Safety Watchman
11. Industry or business Bethelhem Steel Co.

FATHER
12. Name John Hoff
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Sinclair
15. Birthplace Baltimore

16 (a) Informant Mary Agnes Hoff
(b) Address 1620 E 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 10 12 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma; Extension Metastases to brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert C. Fortune M.D. Medical Examiner.
Date signed July 5 1945

G30482
CWK-51783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
94a

Registered No. G30482

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 3- 23
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Klimas'

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
70	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8 '45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Beloit Rd

18 (a) Funeral director Joseph Kasunska
(b) Address 60 Washington Blvd

19 (a) (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945, to July 3 1945, and that I last saw h. im alive on July 3 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Peritonitis?	
Due to Coronary occlusion?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B-E. Hospital Date signed 7/4/45

Huntington Williams M.C.

G30483 G30483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 Race Street (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Miller
13. Birthplace Md

MOTHER
14. Maiden Name Isabella Stevens
15. Birthplace Md

16 (a) Informant Queenie Ward
(b) Address 610 S Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stagg
(b) Address 142 W. Hazel St Huntington Williamsport, Md

19 (a) (Date rec'd by registrar) (b) Registered

VS 90

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945 at 11:35 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed July 4 1945

G30184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G30184

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Nursing Home
(c) Hospital or institution: 4700 Harford Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Babikow Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara J. Winterstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Adam Winterstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22nd 1868

8. AGE: Years: 76 | Months: 10 | Days: 13 | If less than one day: hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name — Kerr
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Geo. C. Winterstein
(b) Address 409 Babikow Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 7 45 (month) (day) (year)

(c) Cemetery or crematory St. Peters Luth.
Location Balto. Co. Md

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd

19 JUL 6 1945 (Date rec'd by Registrar) Huntington Millmans, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1945, at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 4th 1945 to July 5th 1945 and that I last saw her alive on July 4th 1945.

Immediate cause of death: Chronic Myocarditis — Duration: 3 years

Due to:

Due to:

Other Conditions: Chronic Interstitial Nephritis — 5 years
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: —

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gundy M.D.

Address 5106 Harford Rd Date signed 7/5/45

VS 180

G30485

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 132

Registered No. G30485

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green and Lakewood Sts.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 W. Saratoga (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Isabella Perkins
15. Birthplace Va.

16 (a) Informant Mr. James Johnson
(b) Address 663 Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 1918 Druid Hill Ave

19 (a) (Date rec'd by registrar) JUL 6 - 1945 (b) Huntington Williams, M.D.

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4, 12 30 PM 1945, to July 4 4 30 PM 1945, and that I last saw h.. alive on July 4 1945.

Immediate cause of death	Duration
Uremia	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reese R. Boone, Jr. M.D.
Address University Hospital Date signed July 4, 1945

X

G30486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30486

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Coates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Elwood

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Frances Turner

MOTHER 15. Birthplace

16 (a) Informant Elwood Coates

(b) Address 116 N Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director John J Kelly Jr

(b) Address 2455 E Oliver St Huntington Williams MD

1945 (Date rec'd by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5 1945 at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 7-5 1945 and that I last saw her alive on 7-5 1945.

Immediate cause of death a/ eclampsia — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence L. Dalton Jr.

Address St Agnes Hosp Date signed 7/5/45

X

VS 150

G30487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30487

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 N. Luzerne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert A. Manner
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Mary E. Manner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 4 1862
8. AGE: Years 78 Months 3 Days — If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Park Board
11. Industry or business Employee
FATHER 12. Name Emanuel Manner
13. Birthplace Germany
MOTHER 14. Maiden Name Leeder Kellermann
15. Birthplace Germany
16 (a) Informant Mary E. Manner
(b) Address 3629 Mellor Mellor Pl
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7 - 7 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director John E. O'Neill Inc
(b) Address 2435 E. Oliver St.
19 (a) Filed JUL 6 1945 (Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 4 - 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1933 to July 4 1945 and that I last saw h[illegible] alive on 7/3 1945.

	Duration
Immediate cause of death Bronchopneumonia	2 days
Due to Arteriosclerotic C.V. Disease	15 yrs.
Due to Arteriosclerotic gangrene left foot	2 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Karl Grossman M.D.
Address 1212 N Patterson Park Ave Date signed 7/6/45

VS 150

G30488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30488

Registered No. 59877

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo 21 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Flint (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Commonwealth Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Edwin Reuther Bates, Jr.

3 (b) If veteran, name war World war 2

3 (c) Social Security Account No. 378-01-0193

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Alice Buchan BATES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1921

8. AGE: Years	Months	Days	If less than one day
23	9	-	hr. min.

9. Birthplace Flint, Michigan (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Seafaring

FATHER
12. Name Edwin Bates
13. Birthplace Bay City, Michigan

MOTHER
14. Maiden Name Laverne Reuther
15. Birthplace Bay City, Michigan

16 (a) Informant Mrs. Mary Alice Bates
(b) Address R.F.D. 1 Box 63-Traverse City, Mich

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 6 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Detroit Michigan

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 6 1945 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH July 5 1945, at 2:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15 1945, to July 5 1945. and that I last saw him alive on July 5 1945.

	Duration
Immediate cause of death Metastatic sarcoma of the lung	2 yrs
Due to Primary sarcoma of the right upper leg	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 24, 1943
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wiesen, M.D.
Address U.S. Marine Hospital Baltimore 11, Maryland. Date signed 7/6/45

VS 180

G30489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1548 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reuben Duke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Colored	Male	Married

6 (b) Name of husband or wife Hattie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-1906

8. AGE: Years	Months	Days	If less than one day
39	1	26	hr. min.

9. Birthplace N. C. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Duke
13. Birthplace S.C.

MOTHER
14. Maiden Name Addie ?
15. Birthplace S.C.

16 (a) Informant Hattie Duke
(b) Address 1548 Penna ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsa ave

19 (a) JUL 6 1945 (Date rec'd by registrar) Huntington Woltemate, Md Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1945, at 8:10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Shock. Second degree burns.

Due to Acute congestive cardiac failure.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-28-45 at 8:05 A.M. 23/3
(b) Where did injury occur? In the Captain Gas Products Co. Fendendall + Barney St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes
(d) Means of injury? Fell against a tank of hot tar.

23. Signature Howard Knudsen M.D. Medical Examiner.
Date signed June 28, 1945.

G30490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G30490
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W University Pkwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy (If rural give location)
(e) Citizen of foreign country Naturalized (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Goddard -
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 20 1861

8. AGE: Years	Months	Days	If less than one day
83	8	15	hr. min.

9. Birthplace Birmingham, England (Town, county, and state)
10. Usual Occupation Domestic servant.
11. Industry or business

FATHER
12. Name William Goddard -
13. Birthplace Oxford. England -

MOTHER
14. Maiden Name Florence
15. Birthplace Birmingham England

16 (a) Informant Mrs Edward McKeon
(b) Address 100 W. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 6 1945 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Rd

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Richard Ave

19 (a) Filed [illegible] 1945 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 12:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/4 1945 to 7/4 1945 and that I last saw h.e.r. alive on 7/4/ 19 45.

Immediate cause of death Arterio-sclerotic Cardio-vascular Renal — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence Judd M. D.
Address 222 Wendom Road Date signed 7/5/45

X

G30491 G30491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kurt Ehrling

3 (b) If veteran, name war

3 (c) Social Security Account No. 083-14-3965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Eunice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 3, 1902

8. AGE: Years	Months	Days	If less than one day
43	2	23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Mutual Chemical

FATHER
12. Name Ehrling
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Eunice Ehrling
(b) Address 1000 N. Appleton

17 (a) Burial (b) Date thereof July 2 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Cleveland City

18 (a) Funeral director Harry Hutchko
(b) Address 410 Edmondson Ave

19 (a) (b)
Registrar
JUL 6 - 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1945, at 11P. M

21. I certify that I took charge of the remains described above, held an Autopsy & Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10:30 P.M. 6-26-45
(b) Where did injury occur? 1000 Appleton Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed June 27 1945

X

G30498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.164C

Registered No. G30492

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Sq Hosp 19
(c) Hospital or institution St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel H. Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-1920

8. AGE: Years	Months	Days	If less than one day
25	-	14	hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard B. Weaver
13. Birthplace Md.

MOTHER 14. Maiden Name Mary R. Kaupp
15. Birthplace Md.

16 (a) Informant Mrs. Howard B. Weaver
(b) Address 1720 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1945 (month) (day) (year)

(c) Cemetery or crematory Richley Highway
Location Glenhaven

18 (a) Funeral director Harry H. Wilko
(b) Address 4101 Edmondson Ave

19 (a) JUL 6 1945 (Date received by registrar) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 - 1945, at 6 55 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of brain.

Due to

Other Conditions psycho-neurosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-5- at 11 A. M.
(b) Where did injury occur? 1720 W. Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Revolver -

23. Signature Howard J. Mendenhall M.D.
Medical Examiner.
Date signed 7-6-45

(over)

G30493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/32

G30493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Canal St -
(c) Hospital or institution:
5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Canal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Arrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Walter Arrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec - 14 1889

8. AGE: Years 55 | Months 5 6 | Days 21 | If less than one day hr. min.

9. Birthplace Wrenn N-C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Williams Sparrows
13. Birthplace Raleigh N.C

MOTHER
14. Maiden Name Carrie Gilmore
15. Birthplace Raleigh N.C

16 (a) Informant Bertha Hall
(b) Address 1210 Canal St

17 (a) Burial (b) Date thereof July 8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) (b)
(Date received by registrar) Oct 6-1945 Huntington Williams Asst Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1945, at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1945 to 7/4 1945, and that I last saw her alive on 7/4 1945.

Immediate cause of death Cerebral Hemmorrhage — Duration 7 days

Due to Nephritis -

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Crawley M. D.
Address 1210 Canal St Date signed 7/6/45

G30494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95a

G30494 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1237 Carroll St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Macher

3 (b) If veteran, name war: no.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Elizabeth G. Macher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28. 1864

8. AGE: Years	Months	Days	If less than one day
80	10	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Safe Maker
11. Industry or business Miller Safe Factory

FATHER
12. Name Unknown
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Grace May Miller
(b) Address 1237 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9. 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 E. Fayette St

19 (a) JUL 6 - 1945 (b) (Registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945 at 4.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to July 5 1945 and that I last saw him alive on July 5 1945.

Immediate cause of death	Duration
Auricular Fibrillation	1 week
Due to Acute Bronchitis	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E. Gates
Address 517 Scott St. Date signed 7/5/45 M. D.

G30495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30495 Registered No. 2002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/45 (month) (day) (year)
(c) Cemetery or crematory Damascus
Location Damascus, Md.

18 (a) Funeral director Adolphus Hebron
(b) Address 918 Druid Hill Ave.

19 (a) JUL 6 1945 (Date received by registrar)
Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945, at 2 P M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Impossible to determine due to advanced putrefactive changes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Carstater M.D. Medical Examiner.
Date signed July 3rd 1945

X

G30496 ✓ G30496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N. Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 6 N. Pearl St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter S. Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married) widowed, or divorced.
M	W	

6 (b) Name of husband or wife Pauline Chambers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1885

8. AGE: Years	Months	Days	If less than one day
61	?	?	hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Steve Chambers
13. Birthplace Greece

MOTHER
14. Maiden Name Helen Bombakos
15. Birthplace Greece

16 (a) Informant Gus Chambers
(b) Address 6 N. Pearl St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 7 '45 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox Evangelismos
Location Balto, Md

18 (a) Funeral director John Miller
(b) Address Jefferson Pl., Balto, Md.

19 (a) JUL 8 1945 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-45 19 ; at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to 7-3 1945, and that I last saw him alive on 7-3 1945.

Immediate cause of death a. Carcinoma Urinary Bladder — Duration 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dr. Gustave Cooper
Address 2201 Eutaw Place Date signed 7/7/45

VS 180

G30197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Linnard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Linnard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claire E. Jacoby

3 (b) If veteran, name war World War I

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Myrtle Jacoby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1896

8. AGE: Years 49 | Months 0 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace York, Pa.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Ward Baking Co.

FATHER
12. Name Harry E. Jacoby
13. Birthplace Pa.

MOTHER
14. Maiden Name Fannie Zech
15. Birthplace Pa.

16 (a) Informant Mrs. Myrtle Jacoby
(b) Address 621 Linnard St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 7/7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 6 1945 (Date rec'd by registrar) Harrington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 19 45 at 1515 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature A. J. Lubinski M.D.
Medical Examiner.
Date signed 7/14/45

G30198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30198 937 Registered No. 62194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Presbury Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick August Kummell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leslie K. Kummell
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1877

8. AGE: Years	Months	Days	If less than one day
67	7	20	____ hr. ____ min.

9. Birthplace Detroit, Michigan
(Town, county, and state)
10. Usual Occupation Tide Observer
11. Industry or business U S Coast & Geo. Survey

FATHER
12. Name Charles H. Kummell
13. Birthplace Frankfort, Germany

MOTHER
14. Maiden Name Anna Wackwitz
15. Birthplace Dresden, Germany

16 (a) Informant Mrs. Leslie K. Kummell
(b) Address 3116 Presbury St.

17 (a) Burial (b) Date thereof 7/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received 1945 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 5 1945, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945, to July 5 1945, and that I last saw him alive on July 5 1945.

	Duration
Immediate cause of death Auricular fibrillation; cardiac insufficiency	
Due to Hypertension cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson

Address U.S. Marine Hospital Date signed 7/6/45
Baltimore 11, Maryland. X Wilson

G30499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G30499

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2204 Lyndhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Miller Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSHUA B. BRANDENBURG

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ida Garrish Brandenburg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1874

8. AGE: Years	Months	Days	If less than one day
71	3	3	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Operator
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Joshua Brandenburg
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Lydia J.
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Calvin G. Brandenburg
(b) Address Miller Station, Carroll Co., Md.

17 (a) Burial (b) Date thereof 7/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brandenburg Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received 1945 (b) Registrar Huntington Williams, M.D.

JUL 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945 at 3:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to July 4 1945; and that I last saw h[illegible] alive on July 3 1945

Immediate cause of death Cerebral hemorrhage — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger M.D.
Address 402 E. Lanvale St. Date signed 7.5.45

X

G30500 ✓ G30500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4307 Clifton Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Clifton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA C. CREAMER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anthony Creamer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Darsch
15. Birthplace Balto., Md.

16 (a) Informant Mr. Edwin A. Creamer
(b) Address 4307 Clifton Rd.

17 (a) Burial (b) Date thereof 7.7.45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 5, 1945, at 10:45M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943, to July 5 1945. and that I last saw her alive on July 3 1945.

Immediate cause of death	Duration
Carcinoma of Breast	10 Yrs
Due to Metastasis Stomach, and Lungs	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. K. Creamer M. D.

Address 2757 N. Mon. Date 7/6/45

Dvs. 1945 Huntington Williams, Registrar

X

G30501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G30501 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Local Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Conway St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years: 27 | Months | Days | If less than one day: hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name Lazarus Johnson
13. Birthplace S. C.

MOTHER — 14. Maiden Name Pauline Anderson
15. Birthplace S. C.

16 (a) Informant Pauline Williams
(b) Address 652 W Conway Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 6 7/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaac L Burns & Son
(b) Address 108 W Monument St

19 (a) (Date received) Washington Wilmington (Registrar)

JUL 6 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945; at 8 15 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/4

(a) Date of injury 7:20 P.M. 7-2-45
(b) Where did injury occur? Foot of Hanover St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found Drowned

23. Signature Robert L. Fraser M.D. Medical Examiner.
Date signed July 3 1945

G30502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6002 Prescott ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Govans, Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6002 Prescott ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Ford Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	colored	married

6 (b) Name of husband or wife Dottie Lee Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1890

8. AGE: Years	Months	Days	If less than one day
55	0	18	hr. min.

9. Birthplace Govans, Balto. Md.
(Town, county, and state)
10. Usual Occupation chauffeur
11. Industry or business

FATHER
12. Name John E. Ford
13. Birthplace md.

MOTHER
14. Maiden Name Emily Hotson
15. Birthplace md.

16 (a) Informant Mrs Dottie Lee Ford
(b) Address 6002 Prescott ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 6002 Prescott ave. Balto.

6 7 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-45 19..., at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1945 to 7-3-45 19...
and that I last saw him alive on 7-1-45 19...

Immediate cause of death
Congestive Heart failure
Due to Acute myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Sudden
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Odom, M. D.
Address 312 E 23rd St Date signed 7-6-45

VS 150

G30503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30503 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2447 Eager Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2447 Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET EDELMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1862

8. AGE: Years	Months	Days	If less than one day
82 yrs.	7	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Kolb
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ulrich
15. Birthplace Germany

16 (a) Informant Henry Kolb - brother
(b) Address 3507 N. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (Date received by registrar) 7-6-1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 9½ P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1943 to July 5 1945 and that I last saw h[illegible] alive on July 3 1945

Immediate cause of death (a) Pulmonary Embolism
Due to (b) Acute Cardiac Failure
Due to (c) Chronic Nephritis
Due to Arteriosclerosis - generalized.

Duration
1 hour
2 months
10 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
Address 2413 E Monument St Date signed 7/5/45
M. D.

VS 180

G30504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G30504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 S Glover St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 S. Glover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maryanna Pakulska

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Lewandowske
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lillie Pakulska
(b) Address 816 S. Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Dudu
(b) Address 2829 Hudson St.

19 (a) JUL 6 - 1945 (Date received by registrar) Huntington White, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/45 19 , at 3:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/44 19 to 7/5/45 19 , and that I last saw her alive on 7/5/45 19

Immediate cause of death Coronary Occlusion — Duration 3 days

Due to Hypertension Cardiac — 10 yrs

Due to — 10 yrs

Other Condition Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. W. Thompson M.D.

Address 1710 E. 33rd Date signed 7/7/45

X

G30505 ✓ G30505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

948 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 S Potomac St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 S. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Constance F Romanowska

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Peter

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1895

8. AGE: Years 50 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Krzykowski
13. Birthplace Poland

MOTHER
14. Maiden Name Miezejewska
15. Birthplace Poland

16 (a) Informant Peter Romanowski
(b) Address 126 S Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) [illegible] 6 1945 Huntington Williams Inc. Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to July 2 1945, and that I last saw h[illegible] alive on July 2 1945.

	Duration
Immediate cause of death: angina Pectoris	2 hours
Due to: Hypertension	15 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) e at work?
(e) Means of injury

23. Signature Harold L. Krause M. D.
Address 3735 East Ave. Date signed 7/5/45

X

G30506 ✓ G30506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: B. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 N. Camden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Sr. Mable

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Thelma Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1903.

8. AGE: Years	Months	Days	If less than one day
42	2	19	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name David Mabel

13. Birthplace Md.

MOTHER 14. Maiden Name Isabella —

15. Birthplace Md.

16 (a) Informant Ethel Mabel

(b) Address 1412 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St. Pennington Williams, Mgr.

19 (a) 1945 (b) Registrar

6 — 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-1945, at 6.25 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Broken neck
Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26-4

(a) Date of injury 7-2- at 6 p.m.

(b) Where did injury occur? Monument & Harrison Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Fell off from to roof

23. Signature Howard J. Waddell M.D. Medical Examiner.

Date signed 7-3-45

G30507 ✓ G30507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Madison (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgie Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 - 1876

8. AGE: Years 69 | Months 6 | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name
13. Birthplace Md.

MOTHER 14. Maiden Name Martha Howard
15. Birthplace Md.

16 (a) Informant Mrs. Georgie Braxton.
(b) Address 5015 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie P. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) (b) Wilkins Funeral Home

Registered by registrar 6

JUL 6 - 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 45 at 1 A.M.

21. I certify that death occurred on the date above stated, that attended deceased from June 19 19 45 to July 3 19 45 and that I last saw [illegible] alive on July 3 19 45

Immediate cause of death Hypertension | Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 723 Eager Date signed 7/5/45

G30508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 N. Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 N. Gilmor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dessie Collett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles Collett

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 6/17/1870

8. AGE: Years 73 | Months - | Days 21 | If less than one day hr. min.

9. Birthplace D. A. Co. Md (Town, county, and state)

10. Usual Occupation Movie

11. Industry or business

FATHER 12. Name Albert Kensard
13. Birthplace D. A. Co. Md

MOTHER 14. Maiden Name Margaret Parlan
15. Birthplace D. A. Co. Md

16 (a) Informant Mrs. Mamie Boyer
(b) Address 1203 Harlem

17 (a) Burial Burial, cremation, or removal (b) Date thereof 7/5/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Killiany
(b) Address 3227 N. Schroeder St.

19 (a) Date 7-6-1945 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3/1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/1945 to 19 ; and that I last saw h alive on 7/3/45

Immediate cause of death
Due to Cardiovascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation None
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Welcome M. D.
Address 1131 Harlem Date signed 7/5/45

G30509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G30509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1619 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Worthington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22. 1921

8. AGE: Years 23 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Washington D C (Town, county, and state)

10. Usual Occupation

11. Industry or business Waitress

FATHER
12. Name Guy L Worthington
13. Birthplace Washington

MOTHER
14. Maiden Name Josephine Hendrickson
15. Birthplace Washington D C

16 (a) Informant Guy L Worthington
(b) Address 1020 Cathedral

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9th (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Catonsville

18 (a) Funeral director Wm J Fennell Home
(b) Address 200 Williams St

19 (a) (Date received by registrar) July 7 1945 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1945, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-5-45 at 4:30 P. M.
(b) Where did injury occur? Curtis Creek Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Rowboat overturned

23. Signature Howard J. Moseley M.D. Medical Examiner.
Date signed 7-6-45

G30510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30510 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Harlem ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 11 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna E. Mac. Kenzie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Enoch MacKenzie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	16	hr. min.

9. Birthplace Frederick Co Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER 12. Name Mr Brady

13. Birthplace England

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant A. MacKenzie

(b) Address 2741 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)

(c) Cemetery or crematory Loraine Cemetery

Location Woodlawn

18 (a) Funeral director Thos J. Ennis

(b) Address Hollis & Gilmor

19 (a) 1945 (Date received by registrar) (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1945, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 1943 to June 25 1945, and that I last saw h[illegible] alive on June 25 1945.

Immediate cause of death Coronary thrombosis — Duration 1 day

Due to Hypertension arteriosclerosis, Calcific-vascular disease — 10 years

Due to — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Callahan M.D.

Address 24 W. Fayette St Date signed 7/5/45

G30511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a G30511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Parkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Calvin Turnbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1900

8. AGE: Years	Months	Days	If less than one day
45	5	8	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER
12. Name Edward Turnbaugh
13. Birthplace Md

MOTHER
14. Maiden Name Emma May
15. Birthplace Md.

16 (a) Informant Emma Turnbaugh
(b) Address Parkton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto Co Md.

18 (a) Funeral director Jacob Hartenstine
(b) Address New Freedom Pa.

(a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 12:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull

Due to

Other Conditions Fractured ribs, stomach contusions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 5, 1945 M.
(b) Where did injury occur? Parkton, Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? on farm While at work? Yes
(d) Means of injury Fall from farm machinery

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 7-6-45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30512 ✓ G30512

HEP-84457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 302 E. 23½ St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Leslie Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Bertha Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27-1903

8. AGE: Years	Months	Days	If less than one day
41	10	8	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Price

13. Birthplace Virginia

MOTHER 14. Maiden Name Ollie White

15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Shipped (b) Date thereof 7 7 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Columbia Va

Location Virginia

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) 6 JUL 1945 (b) Transcribed from Williamsburg Va Records
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945, to July 4 1945, and that I last saw him alive on July 4 1945.

Immediate cause of death	Duration
Uremia	4 day
Due to urinary retention	
Due to Instrumental trauma of urethra	1 wk.
Other Conditions Acute alcoholism	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

✓ of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thomas J. Oneill M. D.

Address Balto City Hospitals Date signed 7-5-45

X

VS 150

b 30513 - 476528.

BALTIMORE CITY HEALTH DEPARTMENT ✓ b 30513 -

CERTIFICATE OF DEATH 27c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Aliceanna St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Ramicwestki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-27-45

8. AGE: Years	Months	Days	If less than one day
	5	8	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Ramcweski
13. Birthplace Md.

MOTHER
14. Maiden Name Helen Bzgayca
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Fred D Ozazewski
(b) Address 1930 Eastern Ave

19 (a) [illegible] 1945 (Date received by registrar) Washington Avenue, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 5 1945 at 8.1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July - 4 1945 to July - 5 1945 and that I last saw him alive on July 5 1945.

Immediate cause of death	Duration
Hyperpyrexia &	
Due to Dysentery	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence D. Hall Asst Res M. D.
Address Hopkins Hospital Date signed 7-6-45

VS 150

G30514 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G30514

CERTIFICATE OF DEATH 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N Central Ave (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Carroll Hayward ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Infant

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-11-43

8. AGE: Years	Months	Days	If less than one day
		21	..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation ~
11. Industry or business

FATHER	12. Name William Baldwin
	13. Birthplace Fla.
MOTHER	14. Maiden Name Lillian Hayward
	15. Birthplace W.Va.

16 (a) Informant Mrs Baldwin
(b) Address 425 N. Central Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/43 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location.....
18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bloomsbury Ave
19 (a) 4045 (Date received by registrar) (b)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1945, at 6 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho - Pneumonia

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madeira M.D. (Medical Examiner)
Date signed 7-2-45

VS 151 Huntington Williams, M.D.

G30515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G30515

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 Mt. Royal Ave. (Hotel)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Coleman Wyse

3 (b) If veteran, name war: Yes. World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy Thwaites Wyse
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1909
8. AGE: Years 35 | Months 9 | Days | If less than one day ___ hr. ___ min.
9. Birthplace Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Da. W. P. L. Wyse
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Winfred B. Wyse
15. Birthplace Bardstown, Kentucky

16 (a) Informant Wickliff D. Wyse
(b) Address 605 N. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

19 (a) JUL 6 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 5-10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/4/45 at 4:30 P. M.
(b) Where did injury occur? Callonnade Hotel 1333 Mt. Royal Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury fell down stairs

23. Signature Thomas J. Claudio M.D.
Medical Examiner.
Date signed 7-5-45

VS 151

G30516 493909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G30516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1041 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Terry

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	negro	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-13-45

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Wilbur Terry
13. Birthplace Pa.

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 6 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH June 24 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15th 1945 to June 24th 1945 and that I last saw her alive on June 24 1945

Immediate cause of death Prematurity — Duration 1 day

Due to Diarrhea — Duration 10 days

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Davis M. D.
Address J.H.H. Date signed 6-25-45

VS 150

2814 Warren McIverath

G30517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30517 ✓ Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Woodrow Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1924

8. AGE: Years 20 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Pipe, Fitter

11. Industry or business Davidson Chem. Co

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Hilda Parker

15. Birthplace

16 (a) Informant Davidson Chemical Co

(b) Address Curtis Bay, Balto, Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-6-45 (month) (day) (year)

(c) Cemetery or crematory Loudon Cemetery

Location Loudon Baltimore Co.

18 (a) Funeral director Wm. J. Landman & Sons

(b) Address [illegible]

19 (a) [illegible] (b) [illegible]
(Filed by registrar)

JUL 6 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 9A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-5-45 at 8:30 A. M. 11/2

(b) Where did injury occur? Roof: 1308 N. Charles St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Fell from Roof

23. Signature [illegible] M.D.
Medical Examiner.

Date signed July 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G30518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30518
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 N. Charles Street
(c) Hospital or institution: (home apartment)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Virginia County Fayette
(c) City or town Gauley Bridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (none) above (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH MAY PUGH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Clarence W. Pugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-2-1877

8. AGE: Years	Months	Days	If less than one day
67	9	3	hr. min.

9. Birthplace: Erie, Penna. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: None

FATHER
12. Name: William A. Gibson
13. Birthplace: Penna.

MOTHER
14. Maiden Name: could not ascertain
15. Birthplace: Penna.

16 (a) Informant: Miss Geraldine Pugh (daughter)
(b) Address: Gauley Bridge, W. Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July-7-1945 (month) (day) (year)
(c) Cemetery or crematory: Montgomery Memorial
Location: Montgomery, West Virginia

18 (a) Funeral director: Stewart & Mowan Company
(b) Address: 106 W. North Avenue, City.

19 (a) 1945 (b) Huntington, W. Va. Registrar
Registered by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to July 5 1945, and that I last saw her alive on July 5 1945.

Immediate cause of death: Cancer of left breast

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Hollingsworth F. Simms M. D.
Address: Medical Arts Bldg Date signed 7/6/45

VS 180

G30519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. G30519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Wrenwood A-
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Wrenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 - 1870

8. AGE: Years	Months	Days	If less than one day
75	04	29	hr. min.

9. Birthplace Sunbch. N. H.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Delaney
13. Birthplace Ireland

MOTHER
14. Maiden name Annie Carragher
15. Birthplace Ireland

16 (a) Informant S. Barabara Purcell
(b) Address 4408 Wrentwood Av

17 (a) Burial (b) Date thereof July 9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Dover New Hampshire

18 (a) Funeral director John E. Latham
(b) 1945 Boss E Baltimore M.

19 (a) Huntington Williamsport, Md. Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/6 1945 at 3 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hr death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Gilbreath M.D.
Medical Examiner.
Date signed 7/8/45

G30520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

G30520

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Haven Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE A. STEWART

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/4/1902

8. AGE: Years	Months	Days	If less than one day
42	2	27	hr. min.

9. Birthplace Tennessee
(Town, county, and state)

10. Usual Occupation Iron worker
11. Industry or business Stoveland Steel Co.

FATHER
12. Name Will Stewart
13. Birthplace Tennessee

MOTHER
14. Maiden Name Sarah Steel
15. Birthplace Tennessee

16 (a) Informant Elizabeth Dotson
(b) Address 106 S. Haven St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7/45 (month) (day) (year)
(c) Cemetery or crematory
Location Chattanooga Tennessee

18 (a) Funeral director John C. Adam
(b) Address 3000 E. Biddle. M.

19 (a) 1945 (b) Huntington Williams, M.R. Registrar
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Esophageal Varix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Yates M.D.
Medical Examiner.
Date signed July 2 1945

VS 151

G30521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G30521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2332 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Harford Co - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard A. Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
86	-	-	hr. min.

9. Birthplace Fallston Harford Co. Md (Town, county and state)
10. Usual Occupation Landscape Gardener
11. Industry or business

FATHER
12. Name Patrick Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Burke
15. Birthplace Ireland

16 (a) Informant Mrs Eva Martin
(b) Address 2332 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-1945 (month) (day) (year)
(c) Cemetery or crematory St Ignatius Cem
Location Hockey Md

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 32nd St

(c) JUL 7 - 1945 (Date rec'd by Registrar) (d) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1945, at 1, P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to July 2 1945 and that I last saw h.sein alive on July 2 1945

Immediate cause of death Old age — Duration

Due to Arterio Sclerosis

Due to

Other Conditions Blind 27 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Tuckerman M.D.
Address 225 Mundorf Rd Date signed July 6 1945
M. D.

X

G30522

45-93590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G30522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos. 18days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 721 N. Eden St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy-Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13- 1945

8. AGE: Years	Months	Days	If less than one day
	1	18	hr. min.

9. Birthplace Md/ (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Anderson

13. Birthplace Va.

MOTHER 14. Maiden Name Magdalene Murphy

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record

(b) Address 4940 Eastern Ave. 3:00 PM

17 (a) [illegible] cremation, [illegible] (b) Date thereof 7-3-45 at (month) (day) (year)

(c) [illegible] crematory

Location 4940 Eastern Ave

18 (a) [illegible] Baltimore City Hospitals

(b) Address Baltimore City Hospitals (Record

19 (a) JUL 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945, at 3.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13- 1945 to 7-1 1945, and that I last saw him alive on 7-1 1945.

Immediate cause of death (Premature Birth

Due to Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Today

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Warren H. Cowth, M. D.

Address B.C.H. Date signed 7-3-45

x C. Weiseth

VS 150

G30523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G30523

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 S Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Borowy
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-12 3402

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph Borowy
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 9 1879

8. AGE: Years	Months	Days	If less than one day
66	3	27	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at Home

FATHER
12. Name Lawrence Buszkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace —

16 (a) Informant Joseph Borowy
(b) Address 419 S Chapel St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore
18 (a) Funeral director Fred W Ozarowski
(b) Address 1980 Eastern Ave
19 JUL 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to July 6 1945.
and that I last saw h[illegible] alive on July 6 1945.

Immediate cause of death: Carcinoma Cervix — Duration 4 yrs.
Due to
Due to
Other Conditions Hypertension Bronchial Asthma — 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John V. Szczerbacki
Address 1802 Eastern Ave Date signed 7-6-45 M. D.

VS 150

G30524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 B

Registered No. G30524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4209 Sheldon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Sheldon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Ellen Beck
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) July 14 1905

8. AGE: Years	Months	Days	If less than one day
40	11	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Coal Driver
11. Industry or business Hemp H. Martins

FATHER
12. Name Jacob Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E Stapf
15. Birthplace Baltimore Md

16 (a) Informant Mary Ellen Beck
(b) Address 4209 Sheldon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 9 - 45 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem Park
Location Baltimore Ave

18 (a) Funeral director John E Mellystine
(b) Address 4427 Elwin St

19 (a) JUL 7 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 - 5 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 5 1945, and that I last saw him alive on July 3 1945

Immediate cause of death Angina Pectoris — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Martins Jr. M.D.
Address 1125 St Paul Date signed 7/6/45

VS 190

X

G30525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

G30525
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley M. Neal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 2 1924

8. AGE: Years	Months	Days	If less than one day
21	4 3	2	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Homer Neal
13. Birthplace Ohio

MOTHER
14. Maiden Name Ada Ripley
15. Birthplace Ohio

16 (a) Informant Howard Neal
(b) Address 640 W. Fayette st

17 (a) Removal (Burial, cremation or removal) (b) Date thereof 7/7/45 (month) (day) (year)

(c) Cemetery or crematory Woodland
Location Moxton, Ohio

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) JUL 7 1945 (Date received by registrar) [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 10 P.M. 45

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epidural Hemorrhage of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-1-45 at 3A M.
(b) Where did injury occur? Cor. of Fayette & Arch St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt Force

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 5 1945

VS 151

G30526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. X G30526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 6001 Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Leo Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Esther Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1895

8. AGE: Years	Months	Days	If less than one day
50	10	26	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Phelan Printing Co.

FATHER
12. Name Paul Smith
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Shutt
15. Birthplace Md.

16 (a) Informant R C Cayce
(b) Address 3514 Wilbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 7 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945 at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1945 to July 6, 1945 and that I last saw h.IM. alive on July 5, 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Cardiac Decompensation	
Due to Rheumatic C.V.D.	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Brindle M.D.
Address Mercy Hosp. Date signed 7/6/45

X

VS 180

G30527 G30527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 W. Lexington St.

(c) Hospital or institution: Aged Woman's & Aged Men's Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1400 W. Lexington St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Oschlager

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: No Record

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1864

8. AGE: Years 80 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for Aged

FATHER

12. Name John Stein

13. Birthplace

MOTHER

14. Maiden Name Minnie Nichol

15. Birthplace

16 (a) Informant Records Aged Woman's & Aged Men's Home

(b) Address 1400 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Western

Location Balto Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) Received by registrar July 10 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1945, at 1.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20/39 19 to 7/5/45 19.

and that I last saw her alive on 7/4/45 19

Immediate cause of death: Pernicious anaemia.

Duration: known and treated 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edwin B Jones M.D.

Address 11 E. Chase St., City Date signed 7/6/45.

X

G30528 G30528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Forrest St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Bundy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Sadie Bundy
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 30, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	4	hr. min.

9. Birthplace Middlesex Co Va
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Sadie Bundy
(b) Address 325 Forrest Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Belmont Harris & Wright
(b) Address 721 Maguire St

19 (a) Received by registrar 7-7-1945 (b) Huntington for Williams, M.D. Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3 1945 at 7.55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Hugh B. McNabb M.D.
Medical Examiner.
Date signed 7/5/45

X

G30529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G30529 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Huntingdon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace E. Cross.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife Annie B. Cross
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1863

8. AGE: Years	Months	Days	If less than one day
81	9	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter.

FATHER
12. Name Caleb Cross
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Merryman
15. Birthplace Maryland

16 (a) Informant Annie B. Cross.
(b) Address 2615 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore & Frederick Road

18 (a) Funeral director Edmonds & Donovan
(b) Address 2615-17 Edmondson Ave.

19 (a) July 7 - 1945 Interred by [illegible] for Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 15 1945, to July 5 1945, and that I last saw h[illegible] alive on July 4th 1945.

Immediate cause of death
Exhaustion
Due to Recurrent Carcinomatosis
Due to Gastro Intestinal tract.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo. H. E. Cross
Address 29 W 25th St Date signed 7-5-45 M. D.

VS 150

G30530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 194a

G30530

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hood

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose M. Hood.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 20 1884

8. AGE: Years 60 | Months 11 | Days 15 | If less than one day: hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Clark Hood
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sarah L. ?
15. Birthplace Maryland

16 (a) Informant Rose M. Hood
(b) Address 406 W 29th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Brownwell & Brown
(b) Address 3615-17 Chestnut Ave

19 JUL 7 1945 (Date rec'd by registrar) (b) Interring for Williams M.F. (Method)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945 at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 5 1945

G30531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G30531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S.Patomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 S.Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M.Celly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.25,1885

8. AGE: Years	Months	Days	If less than one day
60	4	11	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Vincent
13. Birthplace Italy

MOTHER
14. Maiden Name not known
15. Birthplace Italy

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 7/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Washington Blvd.

18 (a) Funeral director Clarence F.Hoffmahn
(b) Address 1639 N.Broadway

19 (a) 7-10-1945 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5-1945 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to July 5 1945
and that I last saw h[illegible] alive on July 4 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	5 min
Due to Chr. Endocarditis + Arter. & Nephritis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L.M. Lehner Jr. M.D.
Address 1901 Eutaw Pl Date signed 7/6/45

VS 190

1901 Eutaw Place X

G30532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G30532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Appleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CAPT. MARTIN L. TODD

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Minnie B. Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1867

8. AGE: Years	Months	Days	If less than one day
78	3	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Sea Capt.
11. Industry or business

FATHER
12. Name Martin Todd
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma -
15. Birthplace -

16 (a) Informant Mrs. Thelma B. Shropshire
(b) Address 807 N. Appleton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams Mk
Received by registrar JUL 7 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945, to July 4 1945, and that I last saw h— alive on July 4 1945

Immediate cause of death	Duration
Cardiac Arrhythmia	1 dy.
Due to Hypertension	2 yrs.
Due to Arteriosclerosis	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1202 St Paul St Date signed 7/7/45

X

G30533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30533

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2322 Calverton Heights Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2322 Calverton Heights Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: G. Charles Myers

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-0778

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ethel F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3 1904

8. AGE: Years	Months	Days	If less than one day
40	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Beech Nut Co.

FATHER

12. Name Garrison E. Myers

13. Birthplace Jefferson Md.

MOTHER

14. Maiden Name Ethel Gunby

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ethel Myers

(b) Address 2322 Calverton Heights Ave

17 (a) Burial (b) Date thereof 7/9/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons

(b) Address North & Pennsylvania Aves

19 (a) (Date received by registrar) JUL 7 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 3:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945, to July 6 1945, and that I last saw h alive on July 6 1945.

Immediate cause of death: Pulmonary Embolism Lungs.

Duration:

Due to T. B.

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. S. French. M.D.

Address 2329 Druid Date signed 7/9/45

M. D.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully collected. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 639332

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

441 G30534 Registered No. 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Curley
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Jonda (Yanda)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1888

8. AGE: Years	Months	Days	If less than one day
57	4	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Platform Man
11. Industry or business Bakery Equipment Co

FATHER
12. Name James Janda
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not Known
15. Birthplace Bohemia

16 (a) Informant Mary Janda
(b) Address 221 N. Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Francis Grach & Son
(b) Address 900 N. Chester St

19 (a) Filed JUL 7 1945 Registrar
(b) Registered No.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945, to July 6 1945, and that I last saw h im alive on July 6 1945.

Immediate cause of death Chronic Myocarditis
Due to Arteriosclerosis
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Jonda M. D.
Address 444 N. Ellwood Ave Date signed 7/7/45

X

G30535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Hamilton Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 21, 1870

8. AGE: Years 75 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Washington Turner

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden Name Margaret Edenton

15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Bertrude Brookins

(b) Address 1228 - 9th St. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7, 7, 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St

JUL 7 1945 (Date rec'd by Registrar) (b) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1945, 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature D. J. Tubinis Medical Examiner. M.D.

Date signed 7/6/45

VS 151

X

630536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

630536 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1726 E. Lanvale St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME J. Edward Foy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Annie Wheeley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER

12. Name John Henry

13. Birthplace Baltimore

MOTHER

14. Maiden Name Eliza Lancaster

15. Birthplace Baltimore

16 (a) Informant Leroy Foy

(b) Address 1726 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

19 (a) Date rec'd by Local Reg. JUL 7 1945 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/45 19 at 4 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to July 5, 1945. and that I last saw him alive on July 5 1945.

Immediate cause of death Uremia — Duration 5 days

Due to Fracture of Right Hip Joint — 7 wks.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/6

(a) Accident, suicide, or homicide acc.

(b) Date of occurrence 5-13-45 at 11 A. M.

(c) Where did injury occur? 1726 E. Lanvale St (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury Fell down stairs

23. Signature For J. R. Davis, by Howard J. Lawson, M.D.

Address 1601 N. Broadway Date signed 7/6/45

G30537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30537
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga.
(c) Hospital or institution:
Mercy hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs - 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. St. Paul St.
(If rural give location)
(e) Citizen of foreign country? Yes - (Yes or No)
If yes, name country

3 (a) FULL NAME Baby was not named - Baby Wilson.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day 2 hr. 30 min.
9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation Baby -
11. Industry or business

FATHER
12. Name David Wilson -
13. Birthplace Md.

MOTHER
14. Maiden Name Betty Carter -
15. Birthplace Md -

16 (a) Informant Mother
(b) Address 713 St. Paul Street -
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Bowie Md
18 (a) Funeral director Gary & Stanley
(b) Address Fulton & Hayden
19 (a) (Date rec'd by registrar) (b) Registrar

JUL 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1945 at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Birth 19 , to 6-30 1945
and that I last saw h[illegible] alive on 6-30 19 45
Immediate cause of death Respiratory + cardiac failure
Due to Immaturity -
Due to
Other conditions Infected abortion -
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. W. Osborne M. D.
Address Mercy Hos. Date signed 7-5-45

X

G30538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 56 E

G30538 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4310 La Salle Ave
(c) Hospital or institution: University Hospital 2b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Bo
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4310 La Salle Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Edward W. Clemson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Lillie A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/88

8. AGE: Years	Months	Days	If less than one day
56	9	28	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Boiler Em. Engineer
11. Industry or business

FATHER
12. Name Edward Clemson
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary C. Wright
15. Birthplace Maryland.

16 (a) Informant Hosp Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George G Farley
(b) Address Fulton & Fayette

19 (a) (Name rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 JUL 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945, to July 4 1945, and that I last saw him alive on July 4 1945.

Immediate cause of death Acute dilatation of the stomach — Duration

Due to Cardiac failure — Duration

Due to — Duration: over

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation June 26 - 45

Major findings of operation: Gastric tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George R. Callender M. D.
Address Community Hospital Date signed 7-4-45

X

G30539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G30539 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland.

(b) Street address Calvert & Saratoga 27

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5205 Carter Avenue #14

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Elizabeth A Patterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William Patterson

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 4, 1878

8. AGE: Years	Months	Days	If less than one day
67	—	2	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name William Marshall

13. Birthplace Maryland

MOTHER

14. Maiden Name Anna Warnicks

15. Birthplace Maryland

16 (a) Informant William Patterson

(b) Address 5205 Carter Ave #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Balto.

18 (a) Funeral director Leonard D Ruck

(b) Address 5305 Harford Rd

19 (a) ..... (b) Huntington Williams, M. D.

(Date received by registrar) JUL 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945 at 6:14 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945 to July 6 1945; and that I last saw h-x alive on July 6 1945 at 5:00 PM.

Immediate cause of death	Duration
Cardio-respiratory failure	18 hours
Due to Pulmonary Congestion	5 days
Due to Pneumonia Virus	5 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 28, 1945

Major findings of operation: Incarcerated Hernia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Sanchez Jr. M. D.

Address Mercy Hospital Date signed July 6 1945

G30540 G30540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3035 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Fatto~~ Taldo Tarsi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4- 1943

8. AGE: Years 32 | Months 3 | Days 2 | If less than one day hr. min. 1913

9. Birthplace Cincinnati Ohio
(Town, county, and state)

10. Usual Occupation Produce House

11. Industry or business

FATHER
12. Name Gens Tarsi
13. Birthplace Italy

MOTHER
14. Maiden Name Eda Mosca
15. Birthplace Italy

16 (a) Informant Mr & Mrs Gens Tarsi
(b) Address 3035 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) (b) Huntington Williams, M.D. Registrar
(Date received by registrar) JUL 7 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1945, at 5 40 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated, above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-6-45 at 5 A. M.
(b) Where did injury occur? 3035 Northern Parkway
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Illuminating gas—gas heater on gas main.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 6 1945

G30541

AB-83270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30541

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-10-18

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2322 Pennsylvania Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Lydia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife: John Thomas (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1874

8. AGE: Years	Months	Days	If less than one day
70	10	20	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Patrick Addison

13. Birthplace Md.

MOTHER

14. Maiden Name Caroline Fuller

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Md.

18 (a) Funeral director Geo. J. Kelson

(b) Address 1303 Freestman St.

19 JUL 7 1945 Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5- 1945, at 7.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 19 43 to 7-5 19 45, and that I last saw her alive on 7-5 19 45

Immediate cause of death Bronchopneumonia — Duration 6 days.

Due to Pyemia uncertain

Due to

Other Conditions Arteriosclerotic heart disease.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address Bel Air, Md. Date signed 7/6/45

VS 150

630542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 630542

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3358 Strickland
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3358 Strickland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah F. Botts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Herbert L. Botts

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/4/1880

8. AGE: Years	Months	Days	If less than one day
64	10	1	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Sebastian Long
13. Birthplace Md.

MOTHER
14. Maiden Name —
15. Birthplace Md.

16 (a) Informant Stanley L. Botts
(b) Address 3358 Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. B. Wellpott Son
(b) Address 130 Eutaw Place

19 (a) JUL 7 1945 (b) (Date rec'd by registrar) Registrar

Phoning for William

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5th 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to July 5 1945 and that I last saw her alive on July 1 1945

Immediate cause of death Carcinoma of ovary (rt) — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Allen M. D.
Address 3321 Frederick Av Date signed 7-6-45

VS 189

X

G30543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1624 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank R. Baitzel

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1885

8. AGE: Years	Months	Days	If less than one day
60	6	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business Baltimore Transit

FATHER
12. Name Henry Baitzel
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Brockmeyer
15. Birthplace Maryland

16 (a) Informant Mrs. Eliz. Moore
(b) Address 1624 N. Wolfe St.

17 (a) Burial (b) Date thereof 7/10/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balt., Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) JUL 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 19 45, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraser M.D.
Medical Examiner.
Date signed July 7, 1945.

VS 151

G30544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G30544 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Baltimore Forestville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Linford & Green
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Bond.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28, 1945

8. AGE: Years 0 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace University Hospital Baltimore Md

10. Usual Occupation

11. Industry or business

FATHER 12. Name Herbert Bond

13. Birthplace Forest Hill Md

MOTHER 14. Maiden Name Marie L Brown

15. Birthplace Bel Air Md

16 (a) Informant Herbert Bond

(b) Address Forestville Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 9 '45 (month) (day) (year)

(c) Cemetery or crematory Fairview

Location Forest Hill Md

18 (a) Funeral director Martin Ehrlich

(b) Address Forestville Md

19 JUL 9 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945 to July 6 1945, and that I last saw h[illegible] alive on July 6 1945.

	Duration
Immediate cause of death Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E Drake M. D.

Address Univ. Hospital Date signed 7-6-45

VS 150

X

G30545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G30545 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BELLA ADLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed~~, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Morris Zetlein

13. Birthplace Russia

MOTHER 14. Maiden Name Leba ?

15. Birthplace Russia

16 (a) Informant Mr H. R. Smalkin

(b) Address Pikesville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8/45 (Month) (day) (year)

(c) Cemetery or crematory Holy Rood Cemetery

Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bro

(b) Address 1128 Park Ave Northwood Baltimore, Md

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1940, to 7-6 1945, and that I last saw h[illegible] alive on 7-6 1945.

Immediate cause of death: Carcinoma of colon — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address Levindale Date signed 7/6/45 M. D.

VS 150

G30546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30546

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (~~year~~ days) 65
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 7602 Old Hartford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Genco
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Margaret Genco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1894

8. AGE: Years	Months	Days	If less than one day
50 51	6 5	13 19	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shipwater
11. Industry or business

FATHER
12. Name Joseph Genco
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa [illegible] Theotri
15. Birthplace Italy

16 (a) Informant Frank Genco
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9th 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Frank V. Pipitone
(b) Address 218 E. Balto St

19 (a) Filed 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/45 19 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1945 to 7/5 1945 and that I last saw h alive on 7/5 1945

Immediate cause of death Respiratory failure — Duration
Due to Aspiration Pneumonia
Due to Ca of lung & metastases
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Ca of lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Greene, M.D.
Address Union Memorial Hospital Date signed 7/6/45

G30547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

G30547

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Hartford Rd

(c) Hospital or institution: Sydenham Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County East

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1927 Eutaw Pl.

(If rural give location)

(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME William Edward Alloway

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-29-43

8. AGE: Years	Months	Days	If less than one day
1	11	7	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER — 12. Name Edward Alloway

13. Birthplace Penn (Towanda)

MOTHER — 14. Maiden Name Cleta Bland

15. Birthplace Penn (Towanda)

16 (a) Informant Mrs. E. B. Alloway

(b) Address 1927 Eutaw Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/7/45 (month) (day) (year)

(c) Cemetery or crematory

Location Towanda, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 8 1945 (Date received by registrar) (b) Victor Williams MD Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1945 at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1945 to 7-6 1945 and that I last saw him alive on 7-6 1945

Immediate cause of death	Duration
Encephalitis	
Due to Pertussis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy No gross anatomical lesions

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —

23. Signature Margaret H. D. Smith M.D.

Address Sydenham Hosp Date signed 7-6-45

2 Copys

G30548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30548 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3316 Hawkins pt, Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5,
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State / (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3316 Hawkins, pt. Rd,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John H. Hearn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colo.	married

6 (b) Name of husband ~~or wife~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72	7	9	hr. min.

9. Birthplace Delware
(Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name John Hearn
13. Birthplace —

MOTHER
14. Maiden Name Lizie Hearn
15. Birthplace Delware

16 (a) Informant Georgia B. Hearn
(b) Address 3316 Hawkins pt. Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location Dundalk Md

18 (a) Funeral director Robert E. Hillman
(b) Address 1515 McElderry

19 (a) (Date received by registrar) (b) Huntington Williams

JUL 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4th 1945, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to July 4 1945 and that I last saw h[illegible] alive on July 4th 1945

Immediate cause of death

Due to Cerebral hemorrhage

Due to

Other Conditions Cerebral sclerosis Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Rutherford M. D.
Address 203 Patapsco Date signed

X

G30549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G30549 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Union Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Simon W. Kroner.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-4511

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1892

8. AGE: Years	Months	Days	If less than one day
52	6	22	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Textile Worker.
11. Industry or business Kaylon Co.

FATHER 12. Name George N. Kroner.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Kunie Kreiner.
15. Birthplace Germany.

16 (a) Informant Gertrude E. Spurrebank
(b) Address 820 Union Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location

18 (a) Funeral director Edmund P. Donovan
(b) Address 3615-17 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUL 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to July 5 1945 and that I last saw h.. alive on July 5 1945.

Immediate cause of death	Duration
Carcinoma Cardiac End Stomach	2 yrs
Due to	
Due to	
Other Conditions Cachexia & immediate	

(Include pregnancy within 3 months of death)

Date of operation 12/15/43

Major findings of operation: Carcinoma Stomach - malignant

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert J. Healy M.D.
Address 301 Med. Arts Bldg Date signed 7/7/45

G30550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G30550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1145 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (William) Willie Alexander

3 (b) If veteran, name war

3 (c) Social Security Account No. 209-05-1720

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: ——— None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1909

8. AGE: Years 35 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Anderson, S. C.
(Town, county, and state)

10. Usual Occupation Auto Repair work

11. Industry or business

FATHER
12. Name Willis Alexander
13. Birthplace Anderson, S.C.

MOTHER
14. Maiden Name Carrie Cunningham
15. Birthplace Anderson S. C.

16 (a) Informant Ray Alexander
(b) Address 1145 N Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1945 (month) (day) (year)
(c) Cemetery or crematory Westwood Star Cemetery
Location Catonsville Baltimore Co. Md.

18 (a) Funeral director Joseph A Lowery
(b) Address 409 N Mount Street

19. (a) Date received JUL 8 1945 (Registrar) (b) Registrar

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-4-45 at 6:30 P. M.
(b) Where did injury occur? 1609 Laurens St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Shooting, revolver

23. Signature Howard F. Waldeis M.D.
Medical Examiner.
Date signed 7-5-45

G30551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

G30551 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division

(c) Hospital or institution: Provident

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 836 George St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-1916.

8. AGE: Years	Months	Days	If less than one day
29	6	29	hr. min.

9. Birthplace Westmoreland County, Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Gaskins.

13. Birthplace Va.

MOTHER 14. Maiden Name Robert Anna Wilson

15. Birthplace Westmoreland Co. Va

16 (a) Informant Mrs. Mary Staples.

(b) Address 614 N. Arlington Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7, 8, '45 (month) (day) (year)

(c) Cemetery or crematory

Location Fredericksburg Va.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) Harrington Williams, Mgr (Date rec'd by reg. dist.) Registrar

1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/45 19 , at 8⁴⁵ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1945 to 7/5 1945, and that I last saw h e alive on 7/5 1945.

Immediate cause of death Massive Abscess of the Lumbar region

Due to (Organism not found)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James A. Byas M. D.

Address 1514 Division St Date signed 7/6/45

1945 [illegible] 150

G30552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30552 Registered No. 1718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Rockland st
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Kingston Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arden Deaver (ARDEN P. DEVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1930

8. AGE: Years	Months	Days	If less than one day
14	11	11	hr. min.

9. Birthplace Pittsburg Penna
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles R. Deaver
13. Birthplace Penna

MOTHER
14. Maiden Name Mary E. Fitton
15. Birthplace Penna

16 (a) Informant Mr Charles R. Deaver
(b) Address 300 Kingston Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Harry A. Wilhelm
(b) Address 4101 E. Lanvale St
(c) Place of burial or removal Washington or Williamsport Md.

JUL 8 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 19 45, at 1:22A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures Cervical Vertebra

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-6-45 at Rd. 4:45 P. M.
(b) Where did injury occur? 400 Rock Glen Rd. Rockland Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from bicycle

23. Signature Howard J. Russell M.D.
Medical Examiner.
Date signed 7-7-45

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30553

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Walnut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Walnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jackson Lambert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sarah M Hyre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1863

8. AGE: Years	Months	Days	If less than one day
82	1	10	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Retired Minister
11. Industry or business

FATHER
12. Name Job Lambert
13. Birthplace West Virginia

MOTHER
14. Maiden Name Elizabeth Calhoun
15. Birthplace

16 (a) Informant Mrs Sarah Lambert
(b) Address 910 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry A Witzke
(b) Address 4101 E Monument Ave

19 (a) 7-8-1945 (b) Lexington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 3a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1945 to July 7 1945, and that I last saw h alive on July 6 1945

Immediate cause of death	Duration
Broncho-pneumonia	3 days
Due to Myocardial degeneration	4 yrs
Due to Arterio-sclerosis	7 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Todd M.D.
Address 735 N. Fulton Ave Date signed 7/9/45

VS 150

G30554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 115c

G30554 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 S. Curley St. (If rural give location)
(e) Citizen of foreign country? Md (Yes or No) If yes, name country

3 (a) FULL NAME Master Robert M Robb

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 24 1941

8. AGE: Years	Months	Days	If less than one day
4	4	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Guy Robb
13. Birthplace Balto. Md

MOTHER
14. Maiden Name ~~Rose Kaufman~~ Mary Facto
15. Birthplace Balto Md

16 (a) Informant Mary Robb (Mother)
(b) Address 620.S.Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fredrick Road

18 (a) Funeral director Lillye Zyler Co
(b) Address 403 S. Wolfe st.

19 (a) Date rec'd by registrar 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1945, at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 1945, to 7-6 1945, and that I last saw h. alive on 7-6 1945.

Immediate cause of death Ether Anesthetic death

Due to Operation Tonsillectomy & Adenoidectomy

Due to Chronic Tonsillitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Adenoid Tonsils

of autopsy: Normal except for Tonsil & Adenoid

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-6-45 at 10 30 M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital Gen. Rm. (Specify type of place) While at work?
(e) Means of injury Ether Anesthetic Death

23. Signature Robert A Doty M. D.
Address Church Home & Hosp. Date signed 7-6-45

Approved by Howard A. Kelly, M.D.

G30555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30555 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Brookwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 723 Brookwood Rd.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK EARL REUWER

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 216-10-9245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Emma Evelyn Reuwer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1897

8. AGE: Years	Months	Days	If less than one day
48	1	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Certified Public Accountant
11. Industry or business W. T. Cowan

FATHER
12. Name George T. Reuwer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Nellie Boyd
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Emma E. Reuwer
(b) Address 723 Brookwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1945, at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 6 1945, and that I last saw him alive on July 6 1945.

Immediate cause of death: Lobar Pneumonia — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 820 N. Wood St. Date signed 7/8/45

VS 150

G30556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30556

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Westmoreland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James W. West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Annie W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1878

8. AGE Years	Months	Days	If less than one day
67	3	28	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James West
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Bodwell
15. Birthplace N.C.

16 (a) Informant Hosp record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-45 (month) (day) (year)
(c) Cemetery or crematory Nat. Cedar Hill
Location Old Frederick Rd.

18 (a) Funeral director John D. Moran
(b) Address 300 E. Baltimore St.

19 (a) Filed by registrar (b) Registrar

JUL 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6-1945 at 5:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5-1945 to 7-6-1945, and that I last saw h alive on 7-6-1945

	Duration
Immediate cause of death Coronary occlusion	2d.
Due to Coronary Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Infirmary Date signed 7-6-45

G30557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 ✓

Registered No. G30557

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 515 W. Cross Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 515 W. Cross St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Louis Curtis Davis

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Natal

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 8/15/1893

8. AGE: Years 51 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Bal Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis Davis

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Ida Baynard

15. Birthplace Baltimore, Md.

16 (a) Informant Bertie Warner (Sister)

(b) Address 515 W. Cross Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County, Md.

18 (a) Funeral director Chas. H. Cooper

(b) Address 512 N. Carrollton Ave

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 190 1945

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 7/6/45 19____, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to July 7 1945 and that I last saw alive on 7-4- 1945.

	Duration
Immediate cause of death: Carcinoma of Renal pelvis - Neuhead	two
Due to: abscess	
Due to: Metastatic carcinoma of liver	1 wk.
Other Conditions	

(Include pregnancy within 3 months preceding)

Date of operation May 1945

Major findings of operation: at City Hospitals

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. K. Gruesch M.D. M. D.

Address 237 Aramark Date signed

Huntington Williams, MD

B. S. Frenchick

G30558

BALTIMORE CITY HEALTH DEPARTMENT XV G30558
Registered No.

CERTIFICATE OF DEATH 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Ba Co.
(c) City or town Riviera Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 53 Asbury Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Donald Keith Carr

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-16-45

8. AGE: Years 0 | Months 0 | Days 21 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Randolf Carr
13. Birthplace Monroe Co. West Virginia

MOTHER
14. Maiden Name Grace Carr
15. Birthplace JOHNS HOPKINS HOSPITAL

16 (a) Informant Lucanda
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Date received by registrar JUL 8 1945 (b) Registrar Huntington Williams M.R.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to July 7 1945, and that I last saw deceased alive on July 4 1945.

Immediate cause of death: Cessation of breathing — Duration: 20 days

Due to: prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair E. Batson Assistant Resident M. D.
Address Johns Hopkins Hospital Date signed 7/2/45

X

G30559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30559 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 7-14
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country ---

3 (a) FULL NAME Mary Claire O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --- 6/3/1871

8. AGE: Years	Months	Days	If less than one day
74	1	4	___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William O'Brien
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Katherine McCarthy
15. Birthplace Washington D.C.

16 (a) Informant Home for Incurables Record (R.F.)
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) 1945 (Date received by registrar) (b) Harrington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 4 45/a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1940 to 7/7 1945, and that I last saw h[illegible] alive on 7/6 1945.

	Duration
Immediate cause of death: Coronary Occlusion	10 Days.
Due to: Hypertensive Cardio-Vascular Disease	10 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hergenrider M.D.
Address 214 Medical Arts Bldg. Date signed 7/7/45

X

G30560 G30560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Fremont & Lombard Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Joshua Edgar Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Leah Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 17-1867

8. AGE: Years	Months	Days	If less than one day
78	4	22	hr. min.

9. Birthplace: Carroll County Maryland (Town, county, and state)
10. Usual Occupation: Merchant
11. Industry or business: Retired

FATHER
12. Name: Gustavus Barnes
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Emma Barnes
15. Birthplace: Maryland

16 (a) Informant: Roger J. Barnes
(b) Address: New Windsor Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-1945 (month) (day) (year)
(c) Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road

18 (a) Funeral director: D. D. Hutter & Son
(b) Address: Union Bridge & New Windsor Md

19 JUL 9 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1945 to July 9 1945 and that I last saw him alive on July 9 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: William H. Robinson M.D.
Address: University Hosp. Date signed 7/9/45

VS 150

G30561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

~~G30560~~ Registered No. G30561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4511 Schenley Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4511 Schenley Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E Harrod

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Oct 31 1865

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 1865

8. AGE: Years 79 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Harford Co Md (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

FATHER
12. Name George B Harrod
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Elizabeth McFadden
15. Birthplace Harford Co Md

16 (a) Informant Mrs Thomas Walker
(b) Address 4514 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Hampden Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1727 E Fayette St

19 (a) JUL 9 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 12-15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945 to July 7 1945, and that I last saw h. alive on July 7 1945.

Immediate cause of death Coronary Thrombosis — Duration 16 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation No

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Gibson Porter
Address 4822 Roland Ave Date signed 7/9/45

VS 150

X

G30562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G30562

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3620 Roberts Race
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3620 Roberts Race
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Sigmund

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1864

8. AGE: Years 80 | Months 6 | Days 19 | If less than one day hr. min. 22

9. Birthplace Germantown Pa.
(Town, county, and state)

10. Usual Occupation Tobacco Roller Retired

11. Industry or business

FATHER 12. Name Charles H. Sigmund
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Charles H. Sigmund
(b) Address 295 Forrest Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 1214 E. Fort Ave

19 (a) Date received (month, day, and year) July 9 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 6.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945, to July 7 1945, and that I last saw him alive on 7-6 — 1945.

Immediate cause of death Bronchial Pneumonia
Due to pleurisy
Due to Chr. Myocarditis

Duration
6 weeks
2

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidson M. D.
Address 3218 Edstern Ave Date signed 7-7-45

VS 150

G30563

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G30563

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington Street
(c) Hospital or institution: Aged Womens & Aged Mens Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs 8 mo 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MISS MARGARET A. ACHEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 18, 1857

8. AGE: Years	Months	Days	If less than one day
87	8	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Inmate

11. Industry or business Home for Aged

FATHER
12. Name Charles F. Achey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Amelia Schultz
15. Birthplace Frederick, Maryland

16 (a) Informant Aged Womens & Aged Mens Homes
(b) Address 1400 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St. Huntington Williams, M.D.

19 (Date received by registrar) JUL 9 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1945 at 11.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15/ 1927, to 7/6/ 1945, and that I last saw her alive on 7/5/45 19

Immediate cause of death	Duration
Chronic myocarditis with generalized arteriosclerosis.	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarrell M.D.
Address 11 E. Chase St., City. Date signed 7/7/45

VS 150

G20564

Dr. Rujeka
Ed. Leonard Funeral Home

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G20564

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 Hugo Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2724 Hugo Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ruth Gonce

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Edward L. -
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1893

8. AGE: Years	Months	Days	If less than one day
52	4	1	hr. min.

9. Birthplace Baltimore - Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Thomas V. O'Connell
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Gormley
15. Birthplace Ireland

16 (a) Informant Mrs. Edward Gonce
(b) Address 2724 Hugo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

JUL 9 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Hypertension	1 day
Due to Coronary Thrombosis	
Due to Cerebral Hemorrhage	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Rujeka M. D.
Address 800 N Bethune Date signed 7-9-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30565 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G30565

AB-94214

CERTIFICATE OF DEATH 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 504 N. Paca St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August R, Lasinski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875 70?

8. AGE: Years	Months	Days	If less than one day
70?	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Old Frederick Road

18 (a) Funeral director Chapel Funeral Dirs.
(b) Address 2013 Queen Anne Ave.

19 (a) June 22, 1945 (Date rec'd by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20- 1945, at 7.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16- 1945, to 6-20- 1945, and that I last saw h im alive on 6-20- 1945.

Immediate cause of death	Duration
Uremia	3-4 days
Due to Bile Nephrosis	? Subs.
Due to Obstructive Jaundice	? Subs.
Other Conditions Carcinoma Head Pancreas	?

(Include pregnancy within 3 months of death)

Date of operation 6-20-45
Major findings of operation: Obstructive Jaundice
of autopsy: Ca. Head Pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 6-21-45

VS 150

G30566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G30566 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Laurens St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Laurens St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem.	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-1860

8. AGE: Years	Months	Days	If less than one day
84 85	6	29	hr. min.

9. Birthplace St. Marys Co. Md. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Charity Beale
15. Birthplace St. Marys Co. Md.

16 (a) Informant Katie Johnson
(b) Address 650 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Wm. Geo. H. Stafford
(b) Address 1631 Druid Hill Ave

19 (a) JUL 9 1945 (b) (Date received) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6-1945; at 7 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20-1945 to 7-6-1945, and that I last saw h-- alive on 7-6-1945

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 3 mos.
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Page M. D.
Address 1617 N. Monroe St. Date signed 7-5-45

G30567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4736 Park Heights Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 4736 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON RHODE

3 (b) If veteran, name war —
3 (c) ~~Social~~ Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Feliz Baer
13. Birthplace Poland

MOTHER
14. Maiden Name Zelda
15. Birthplace Poland

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Pinelawn
Location Rockville Pike & Hamilton Ave

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Belvedere St

19 (a) 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/45 19 , at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 7/8/45

VS 151

G30568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30568 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun Street
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 N Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rachael –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-82

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Brushmaker

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name –
15. Birthplace Russia

16 (a) Informant Mrs. Schwartz
(b) Address 1638 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1131 E. Balt-St

19 (a) (Date received by registrar) (b) Huntington Williams, Md. Registrar

JUL 9 – 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 1 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1945 to 7-9 1945, and that I last saw him alive on 7-9 1945

Immediate cause of death Arteriosclerotic cerebral hemorrhage accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. K. Kerzner M. D.
Address 7 Franklin Sq Hosp Date signed 7-9-45

G30569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G30569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Wordsley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Worsley

3 (a) FULL NAME Howard Bland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. Smith
(b) Address 308 Wordsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUL 9 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1945, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Edema of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed July 6 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

355289570

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 630520

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Purcell Wallace

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-16

8. AGE: Years	Months	Days	If less than one day
29	5	4	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Hampton Anderson
13. Birthplace S. C.

MOTHER 14. Maiden Name Mary Bumble
15. Birthplace S. C.

16 (a) Informant Rescue Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Whitehead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to July 2 1945 and that I last saw her alive on July 2 1945

Immediate cause of death	Duration
Diabetic Acidosis	
Due to Diabetes Mellitus	
Due to	
Other Conditions Tumor of Injection of uterus. (Include pregnancy within 3 months of death)	

Date of operation None.
Major findings of operation:
of autopsy: Small uterine tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph R. Stevenson M. D.
Address 7-3-45 Date signed 7-3-45

G30571 — BALTIMORE CITY HEALTH DEPARTMENT — G30571 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mt. East Balto. Gen'l Hosp.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Brookfield Ave. Belmar Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Julian Plant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1899

8. AGE: Years	Months	Days	If less than one day
46	5	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Meyer Plant,
13. Birthplace Germany

MOTHER 14. Maiden name Henrietta Sternberger,
15. Birthplace New York

16 (a) Informant Miss. Bessie Plant,
(b) Address Belmar Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)
(c) Cemetery Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Levy Funeral Home
(b) Address 1902 Eutaw Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 4:4 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Fractures of Ribs, Pneumothorax, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 8 1945 9:15 P.M.
(b) Where did injury occur? Liberty Hgts. & Pinkerton Rd
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by Vehicle

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 8 1945

G30572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46B

G30572

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas P. McCaffrey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1879

8. AGE: Years	Months	Days	If less than one day
65	2	19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Gardener.
11. Industry or business

FATHER
12. Name Duncan
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Malley
15. Birthplace Delaware

16 (a) Informant Family
(b) Address 818 Light St.

17 (a) B. (b) Date thereof 7-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Old Frederick Rd.

18 (a) Funeral director James F. McCauley
(b) Address 150 E. Lee St.

JUL 9 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 19 45 to July 8 1945; and that I last saw him alive on July 5 19 45.

Immediate cause of death
Exhaustion
Due to Carcinoma of Stomach with Mets
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration
2 Mo.
Mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Campbell M.D.
Address 164 W. Lanvale Date signed 7/9/45

G30573 Relehan G30573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Relehan

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife: S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1918.

8. AGE: Years	Months	Days	If less than one day
26	9	24	hr. min.

9. Birthplace: Md.
(Town, county, and state)
10. Usual Occupation: Ship Yard Worker
11. Industry or business: Ship Building

FATHER
12. Name: John T. Relehan.
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Farley
15. Birthplace: Md.

16 (a) Informant: Family
(b) Address: 1743 Hanover St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-10-45 (month) (day) (year)
(c) Cemetery or crematory: Loudenslager
Location: Old Frederick Rd.

18 (a) Funeral director: J. McCauley
(b) Address: 130 S. Fremont Ave.

19 (a) JUL 9 - (Date rec'd by registrar) Huntington-Williams Mfg

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 1:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured skull

Due to:

Other Conditions: Ruptured Liver & Kidney
Multiple fractures
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23-3
(a) Date of injury July 7, 1945 1:00 a.m.
(b) Where did injury occur? Hanover & Cromwell Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: car struck pole & overturned

23. Signature: Howard J. Mullen M.D.
Medical Examiner.
Date signed 7-7-45

VS 151

X

G30574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G30574

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Wohn

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Henry Wohn

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1885

8. AGE: Years 59 | Months 7 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation home maker

11. Industry or business

FATHER — 12. Name Sarnouski

13. Birthplace Poland

MOTHER — 14. Maiden Name - Grommyer

15. Birthplace

16 (a) Informant Miss Katherine Wohn

(b) Address 1731 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received by local registrar JUL 9 1945 (b) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 11:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1945 to 7/8 1945, and that I last saw her alive on 7/8 1945

Immediate cause of death (Cardiac failure) ~~Hypertension~~ Coronary occlusion

Due to Hypertension Kardio-vascular disease

Due to Arteriosclerosis C.V.D.

Other Conditions Bronchial Branch Block, left, Compl. Heart Block

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Richard Compton

Address Hosp. for Women Date signed 7/9/45

G30575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G30575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Shuter Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD CHAPMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1938

8. AGE: Years	Months	Days	If less than one day
7	5	19	hr. min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER 12. Name Edward Chapman

13. Birthplace Md

MOTHER 14. Maiden Name Lorraine Towns

15. Birthplace Md.

16 (a) Informant Lorraine Chapman

(b) Address 823 Shuter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location A. A. County Md.

18 (a) Funeral director Mrs. Robert E. Cleaver

(b) Address 1129 N. Carolina St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

AUG 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1945 at 5:10P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebra

Cervical

Due to

Other Conditions Fractured skull.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 5 P.M. xx 7-6-45 xx

(b) Where did injury occur? Ashland & Montford Aves.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by truck

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 7-7-45

OK to G30576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30576 122 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution: Lombard & Greene
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 dy
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Sparks (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Thornton Mill Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. ~~Mrs~~ ~~Mary~~ ~~Alice~~ STARR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	26	hr. min.

9. Birthplace Sparks, Balto Co., Md (Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Ed. V. Starr
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Alice Frame
15. Birthplace Howard Co., Md.

16 (a) Informant J. C. O'Donovan
(b) Address Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1945 (month) (day) (year)

(c) Cemetery or crematory Bosleys
Location Sparks, Md

18 (a) Funeral director Landis M. Brooks
(b) Address Sparks, Md

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 9 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-1945, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1945, to 7-9-1945, and that I last saw her alive on 7-9-1945.

Immediate cause of death	Duration
Congestive Heart failure	
Due to Intestinal obstruction	
Due to Strangulation of the small intestine	
Other Conditions Diabetes, Cardio-Vascular-Renal d., Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard D. Thomas M.D.
M. D.
Address Univ. Hospital Date signed 7-9-45

G30577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G30577

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 Bradley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Bradley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Falls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: James Falls
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1896

8. AGE: Years 48 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Greenville S.C.
(Town, county and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name Sherman Williams
13. Birthplace South Carolina

MOTHER
14. Maiden Name Georgia Westmoreland
15. Birthplace

16 (a) Informant Wilton Williams
(b) Address 738 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3221 N. Schroeder St

19 (a) (Date received by Registrar) 1945 Wilton Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1945, at 10 A.M. 35

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fricker M.D.
Medical Examiner.
Date signed July 4 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

✓ G30578 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: George Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife: Celia (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? ? 187?

8. AGE: Years	Months	Days	If less than one day
75 ?			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Tilghman (D)
13. Birthplace ?

MOTHER
14. Maiden Name Emily Wilson (D)
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location Baltimore Md

18 (a) Funeral director Wm. Francis A. Hensley
(b) Address 579 W. Biddle St.

19 (a) JUL 9 1945 (Date received by registrar) Registrar

Huntington Hillsman, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24, 1945, to July 7, 1945, and that I last saw him alive on July 7, 1945

Immediate cause of death	Duration
respiratory failure	
Due to cardiac failure	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address BCD. Date signed 7/8/45

X

G30579

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

116

Registered No. G30579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st Street
(c) Hospital or institution: US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Montgomery
(c) City or town Rockville (If outside city or town limits, write RURAL and give town)
(d) Street No. Veirs Hill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM JOSEPH HOGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Marcella Hogan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1886

8. AGE: Years	Months	Days	If less than one day
59	0	27	hr. min.

9. Birthplace Rockville, Maryland (Town, county, and state)
10. Usual Occupation Field Employee---USPHS
11. Industry or business US Public Health Service

FATHER
12. Name Lawrence Hogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Carlin
15. Birthplace Connecticut

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-9-45 (month) (day) (year)
(c) Cemetery or crematory
Location Bethesda Md.

18 (a) Funeral director Wm Reuben Pumphrey
(b) Address Bethesda, Md.

19 (a) (b)
Registrar
JUL 9 - 1945 Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1945, at 7:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1945, to July 8, 1945, and that I last saw him alive on July 8, 1945.

Immediate cause of death	Duration
Hemorrhage from gastro-intestinal tract	Terminal
Due to Esophogeal stricture	2 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address US Marine Hospital, Baltimore, Maryland Date signed 7/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30580

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 W. Barre St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name Cordilia White

15. Birthplace Md.

16 (a) Informant Cordilia White

(b) Address 643 W. Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 200 Broadway and

(a) JUL 9 - 1945 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945 at 10:05 A M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1945 to July 6 1945, and that I last saw h[illegible] alive on July 6 1945.

Immediate cause of death Cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 6 hr

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 733 [illegible] Date signed July 7 45

G30581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G30581

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Reynor + Dunkland Ave

(c) Hospital or institution: West Balto Gen Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1206 W. Cold Spring La. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mary E. Trail (TRAIL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife W. LeRoy Trail

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Oct. 19. 1887

8. AGE: Years 57 | Months 8 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business at home.

FATHER 12. Name Mark Fahey

13. Birthplace Ireland

MOTHER 14. Maiden Name Fahey.

15. Birthplace Ireland.

16 (a) Informant W. LeRoy Trail

(b) Address 1206 W. Cold Spring La.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 7/11/45 (month) (day) (year)

(c) Cemetery or crematory St. Marys

Location Hyattsville

18 (a) Funeral director Co Verna Lansman.

(b) Address 4611 Park Heights Av.

19 (a) 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/45 19 , at 730 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6/45 19 , to 7/8/45 19 , and that I last saw h alive on 7/2/45 19 .

Immediate cause of death Respiratory failure — Duration

Due to Metastatic Carcinoma

Due to Ca of Ovary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/3/45

Major findings of operation: Metastatic Ca

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James A. Dunham M. D.

Address West Balto Gen Hospital Date signed 7/8/45

VS 180

X

G30582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30582

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 N. Lakewood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Somerset
(c) City or town Deal's Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB J. WEBSTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced, Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1854

8. AGE: Years 91 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Deals Island, Md
(Town, county, and state)

10. Usual Occupation Waterman

11. Industry or business

FATHER
12. Name Jessie Webster
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Williams
15. Birthplace Md

16 (a) Informant Mrs Jessie Webster
(b) Address 1106 Lakewood Ave

17 (a) Burial (b) Date thereof 7-11-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem
Location Deals Island Md

18 (a) Funeral director A. L. Rusk
(b) Address 530 S. Stockton St. Huntingtown Williams Hgts

19 (a) 7-9-1943 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/43 19 , at 2:10 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 7/8/43

VS 151

Please write in ink, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G30583
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Glenmore ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 44.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Glenmore ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Holbrook.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife: Sallie V. Moore.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 31-1878.
8. AGE: Years 67 | Months 1 | Days 7 | If less than one day: hr. min.
9. Birthplace Philadelphia (Town, county, and state)
10. Usual Occupation Y.M.C.A. Bowling Alley Mgr.
11. Industry or business Coatesville Pa Y.M.C.A.
FATHER 12. Name Dr. Chas. Holbrook.
FATHER 13. Birthplace Philadelphia Pa
MOTHER 14. Maiden Name Unknown
MOTHER 15. Birthplace Pa.
16 (a) Informant David D Gilbert
(b) Address 3409 Glenmore Ave Balto Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)
(c) Cemetery or crematory Fairview Cem
Location Coatesville Pa
18 (a) Funeral director Leonard Hirsh
(b) Address 522 N. Howard St.
19 (a) Filed July 9 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 8 - 1945 at 8.04 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to July 8 1945, and that I last saw h alive on July 6 1945.

Immediate cause of death: Cerebral Hemorrhage
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Burke Bayly M. D.
Address 521 Howard St. Date signed 7/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

VS 150

G30584 Sarah Wells G30584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
+83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light St
(c) Hospital or institution: So. Balto General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel Co.
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Smithfield St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sabial Wells

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Married

6 (b) Name of husband or wife Arthur Wells.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Sapal
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Brown
15. Birthplace Md.

16 (a) Informant Arthur Wells
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem
Location A. A. Co. Md.

18 (a) Funeral director B. L. Hoffman
(b) Address 170 West St Annapolis

19 (a) (Date rec'd by registrar) (b) Jos. Williams, Registrar
JUL 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1945 to 7-9 1945, and that I last saw h alive on 7-9 1945.

Immediate cause of death Cerebral vascular accident

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger M. D.
Address 1213 Light St Date signed 7-9-45

G30585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G30585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3944 Cloverhill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3944 Cloverhill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Whitney Schlutter

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	none	Male	White	married

6 (b) Name of husband or wife Clara Desmond Schlutter
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug. 30. 1901

8. AGE: Years	Months	Days	If less than one day
43	10	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name C. F. August Schlutter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bertha Catherine Kimpel
15. Birthplace Baltimore

16 (a) Informant Mrs. Clara D. Schlutter
(b) Address 3944 Cloverhill Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul. 11. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945 at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpeus M.D. Medical Examiner.
Date signed 7-9-45

VS 151

G30586 ✓ G30586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 MT. HOLLY STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Mt HOLLY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WILSON BEVANS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 220-14-8930

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: LYDIA TAYLOR BEVANS

6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Jan 5, 1875

8. AGE: Years: 70 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: Severn Apts

FATHER
12. Name: James LawrenceBevans
13. Birthplace: Stemmers Run, Md

MOTHER
14. Maiden Name: Sarah Francis Peduzzi
15. Birthplace: Balto, Md

16 (a) Informant: Mrs. Lydia Taylor Bevans
(b) Address: 2907 Mt Holly St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cemetery
Location: Baltimore, Md

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Data to be filled by registrar) Huntington Williams M.D. Registrar

7-9-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7, 1945 at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15 1945 to July 7 1945.
and that I last saw h im alive on July 6, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	about 15 min
Due to Myocarditis	about 5 mo.
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Charles J. Tibbett M.D.
Address 2220 Harrison Blvd Date signed 7/9/45

X

G30587 ✓ G30587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2551 Francis Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 Francis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa Di Pisa
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Joseph Di Pisa
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 27 1878
8. AGE: Years 66 Months 7 Days 12 If less than one day hr. min.
9. Birthplace Sicily - Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Vincent Gloriso
13. Birthplace Sicily
MOTHER 14. Maiden Name Concetta Caucciolese
15. Birthplace Sicily
16 (a) Informant Vincent Di Pisa
(b) Address 2904 Arlington Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 - 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cathedral
Location Frederick Road
18 (a) Funeral director Frank V. Lyttle
(b) Address 2818 E. Baltimore st
19 (a) 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 8:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945, to July 8 1945, and that I last saw h[illegible] alive on July 8 1945.

Immediate cause of death Coronary Sclerosis — Duration ?
Due to
Due to Carcinoma Sarcoma renal — ?
Other Conditions Disease Arteriosclerosis & hypertension
(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles L. Wenner M. D.
Address 421 Md. Ave. Bldg Date signed 7-8-45

VS 150

X

G30588 G30588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 475924 134a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John's Hopkins Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore (or Sparrows Point)
City or town Baltimore (or County)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6508 North Point Road P.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Wheaten (TOMCZEWSKI)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White	married

6 (b) Name of husband or wife Andrew.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 9-4-1880

8. AGE: Years	Months	Days	If less than one day
64.	10	1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Home Wife.
11. Industry or business

FATHER
12. Name Martin E.
13. Birthplace Poland

MOTHER
14. Maiden Name ? ?
15. Birthplace Poland.

16 (a) Informant Records
(b) Address [redacted]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 10 45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

JUL 9 - 1945 (Date rec'd by registrar) (b) Signature for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 5 1945 at 10.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 22 1945 to July - 5 1945 and that I last saw h M alive on July - 5 1945

Immediate cause of death: Probable pulmonary embolism, massive — Duration

Due to Phlebothrombosis

Due to Post operative complications -

Other Conditions: Nephrolithiasis -
(Include pregnancy within 3 months of death)

Date of operation 6-29-45

Major findings of operation: Nephrolithiasis — nephrolithotomy, rt - done

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address 20 N. Broadway Date signed 7-3-45

G30589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G30589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stanowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stephen Stanowski
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sophia Kobus
15. Birthplace Baltimore Md

16 (a) Informant Stephen Stanowski
(b) Address 607 S Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10/45 (Month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Dyszewski
(b) Address 1930 Eastern Ave

19 (a) JUL 9 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 8:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1945, to July 9 1945, and that I last saw him alive on July 9 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Phyllis P. Sugrue M. D.
Address Church Home + Hosp. Date signed 7/9/45

G30590 ✓ G30590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution:
MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2439 Barclay St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY BRANDT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Single

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Edward Brandt
FATHER 13. Birthplace West Virginia
MOTHER 14. Maiden Name Helen O'Connor
MOTHER 15. Birthplace Pennsylvania

16 (a) Informant Wm. O'Connor
(b) Address 6012 Harford Rd., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Dolphin Cem
Location Baltimore

18 (a) Funeral director L. L. Redrick
(b) Address 5306 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 10:55 M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1945 to July 9 1945 and that I last saw him alive on July 9 1945

Immediate cause of death PREMATURITY — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick
Address Mercy Hospital Date signed 7/9/45 M.D.

1945

G30591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. G30591

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Loraine
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Duane Apartments
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARVEY REID IRVIN, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	~~Married~~/Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24, 1921

8. AGE: Years	Months	Days	If less than one day
23	6	15	hr. min.

9. Birthplace Cleveland, Ohio
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Harvey Irvin
13. Birthplace ------

MOTHER
14. Maiden Name Josephine Beaudry
15. Birthplace ------

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)
(c) Cemetery or crematory
Location Torraine Ohio

18 (a) Funeral director A. Lee Odenbach
(b) Address 1644 York Road

19 (a) Filed 1945 (b) Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945 8:20a.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1945, to July 9, 1945, and that I last saw h. in alive on July 9, 1945

Immediate cause of death	Duration
HODGKINS DISEASE	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.

Address US Marine Hospital, Baltimore, Md. Date signed 7/9/45

G30592

HEALTH DEPARTMENT—CITY OF BALTIMORE

G30592

CERTIFICATE OF DEATH

X 115c

1. PLACE OF DEATH Presbyterian Hospital — Registered No. 4112

CITY OF BALTIMORE: (No. 1017 E Baltimore St Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. How long in U. S. If of foreign birth? — yrs. — mos. — ds. If U. S. Veteran specify WAR —

2. FULL NAME Robert C. Cade / Cole

(a) Residence: No. Perryville Md St., — Ward. Cecil County (If non-resident give city or town and State)

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 9/21/43

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	9	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 0

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 0

10. Date deceased last worked at this occupation (month and year) 0

11. Total time (years) spent in this occupation 0

12. BIRTHPLACE (city or town) (State or country) Perryville Md

FATHER

13. NAME David Cade

14. BIRTHPLACE (city or town) (State or country) Perryville Md

MOTHER

15. MAIDEN NAME Gertrude Cochran

16. BIRTHPLACE (city or town) (State or country) Perryville Md

17. INFORMANT Hospital Records

(Address) 1017 East Balto. St

18. BURIAL, CREMATION, OR REMOVAL

Place Perryville, Md Date July 12 1945

19. UNDERTAKER C. A. Cuthbertson & Son

(Address) Perryville, Md

20. FILED JUL 10 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 7-9- , 1945

22. I HEREBY CERTIFY, That I attended deceased from July 3 - , 1945 to July 9 - , 1945 last saw ... alive on July 8 - , 1945 Death is said to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemorrhage of throat	7-3-45
Secondary to tonsillectomy	

Other contributory causes of importance:

Malnutrition

Since birth

Was an operation performed? Yes Date of 7-3-45

For what disease or injury Chronic Tonsilitis

Name of operation Tonsillectomy Date of 7-3-45

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury ..., 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify —

(Signed) James G. Maccoore M.D.

(Address) 100 St Paul St

X

G30593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. G30593

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Calhoun St
(c) Hospital or institution: Franklin Sq. 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 E 31st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Tall

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Margaret Tall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-23-1861

8. AGE: Years 83 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Retired Real Estate Dealer
11. Industry or business

FATHER
12. Name Joseph Tall - W
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sara ?
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Margaret Tall
(b) Address 1825 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 7 1945, and that I last saw him alive on July 7 1945.

Immediate cause of death	Duration
Acute Myocardial failure	
Due to Uremia	
Due to Renal insufficiency	
Other Conditions Edema of the lungs. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin
Address Franklin Square Hospital Date signed 7/11/45

G30594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G30594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AARON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2872 Harford Road
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2872 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Kesting
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Martin J. Kesting
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Apr 15. 1874

8. AGE: Years	Months	Days	If less than one day
71	2	22	hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Stephen D. Gibson
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Ward
15. Birthplace Md.

16 (a) Informant Martin J. Kesting
(b) Address 2872 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Mc. Nus. John W. Teufel & Son
(b) Address 801 W. Fayette St.

JUL 10 1945 Huntington Williams M.D. (Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8. 1945, at 12 a M 52

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3-1940 to 7-8-1945, and that I last saw her alive on 7-7-1945.

Immediate cause of death: Arteriosclerotic cardio-renal disease — Duration: Uncertain

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. B. Dybert M. D.
Address 780 Harford Rd Date signed 7-8-45

X

G30595

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G30595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Balto. Comford & Greene Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Road to Glyndbrook (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna M. Bishop
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife John T. Bishop
(c) If alive, give age 68 yrs

7. Birth date of deceased (mo., day, yr.) July 28, 1876

8. AGE: Years 68 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Charles Mayer
13. Birthplace Balto Md

MOTHER 14. Maiden Name Caroline Hermann
15. Birthplace Berlin Germany

16 (a) Informant John T. Bishop
Owings Mills Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

(c) JUL 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 9 1945 and that I last saw her alive on July 5 1945

Immediate cause of death Uremia

Due to Hypertension C.V.R. disease

Due to

Other Conditions Ca of cervix removed

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Guy M. D.
Address Balto, Md Date signed 7/12/45

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G30596
AB-93330

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G30596
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos-7days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Shakespeare St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Peterson or Margaret Petterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Helfton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1911

8. AGE: Years	Months	Days	If less than one day
33	7	2	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Wheelas or Whillas Hewitt (D)
13. Birthplace Georgia

MOTHER
14. Maiden Name Mamie Jones
15. Birthplace Georgia

16 (a) Informant Baltimore City Hospitals (Rec...)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10th 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 10 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 6th 1945, at 8.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-9 1945, to 7-6 1945, and that I last saw her alive on 7-6 1945.

Immediate cause of death	Duration
respiratory failure	
Due to Pulmonary TBC	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M.D.
Address 15 E 10 Date signed 7/8/45

VS 150

X

G30597

CWK-94552

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G30597 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 65- 5- 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Henry Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13-1880

8. AGE: Years	Months	Days	If less than one day
65	5	23	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Arundel Corporation

FATHER
12. Name Charles Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name ?? Twelbeck
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St.

19 (a) JUL 10 1945 Huntingtor Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1945, to July 6 1945, and that I last saw him alive on July 6 1945.

Immediate cause of death	Duration
Dextrocardiac failure	
Due to coronary occlusion	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: arteriosclerosis

of autopsy: Pulmonary oedema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 7/7/45

VS 150

G30598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

Registered No. G30598

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Pigott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-45

8. AGE: Years | Months: 6 | Days: 5 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Leroy Pigott
13. Birthplace S.C.

MOTHER
14. Maiden Name Rhyna Mae Rose
15. Birthplace S.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location 9 A County

18 (a) Funeral director Mrs Bessie A. Elliott Dept
(b) Address 129 N. Caroline St

19 (a) Date registered JUL 10 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 45, at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 45 to July 9 19 45 and that I last saw h[illegible] alive on July 9 19 45.

Immediate cause of death: Septicemia

Due to: Pyocyaneus

Due to: Congenital Syphilis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena A. Hall Asst Res M. D.
Address Hopkins Hospital Date signed 7-9-45

G30599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30599 190C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eldridge Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1926

8. AGE: Years	Months	Days	If less than one day
19 18	2	5	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

FATHER
12. Name Floyd Adams
13. Birthplace Va.

MOTHER
14. Maiden Name Viola Bell
15. Birthplace Va.

16 (a) Informant Viola Adams
(b) Address 1007 Gay St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 11/45 (month) (day) (year)

(c) Cemetery or crematory
Location Greenbay Virginia

18 (a) Funeral director Mrs. Robt A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) JUL 10 1945 Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH July 9, 1945, at 1 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/9

(a) Date of injury 12:30 A.M. 7-9-45

(b) Where did injury occur? Federal & Eden Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Collision of auto & Streetcar

23. Signature Robert Lee Gunter M.D. Medical Examiner.

Date signed July 9 1945

Washington Williams, M.D.

G30600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30600 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 S Glover St.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 S. Glover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Chronowski (Hronowski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maryanna
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 16, 1877

8. AGE: Years	Months	Days	If less than one day
68	3	22	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Walenty Chronowski
13. Birthplace Poland

MOTHER
14. Maiden Name Katarzyna Kwoka
15. Birthplace Poland

16 (a) Informant Maryanna Chronowska
(b) Address 810 S Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) JUL 10 1945 (Date received by registrar) Huntington Williams, M.D. Registrar Address 1710 E 32

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8/45 at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4/43 19 to 7/8/45, and that I last saw h[illegible] alive on 7/8/45.

Immediate cause of death	Duration
Myocardial Degeneration	6 mos
Due to	
Due to Chronic Complete Hemiplegia Bronchitis	1 day
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature + J. J. Harrigan M.D. Physician
Address 1710 E 32 Date signed 7/9/45

VS 160

G30601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30601 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1613 E. Chase st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1613 E. Chase st (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Robert Fisher

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mary Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1867

8. AGE: Years	Months	Days	If less than one day
78	4	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Packer

11. Industry or business Balto. Bargain House

FATHER

12. Name Isaac Fisher

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Elizabeth Gibbons

15. Birthplace Balto. Md.

16 (a) Informant Mary Fisher

(b) Address 1613 E. Chase st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul st.

19 (a) 10145 (Filled in by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1945, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6th 1945 to July 8th 1945, and that I last saw him alive on July 8th 1945.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry H. Rosenthal M.D.

Address 1902 Greenmount Ave. Date signed 7/9/45

VS 180

X

G30602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G30602

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1053 W. Fairmount Ave, Baltimore, Maryland

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits write RURAL and give town)

(d) Street No. 1053 W. Fairmount Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1923

8. AGE: Years 22 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace Wilmington, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Papa Smith

FATHER 13. Birthplace Wilmington, N.C.

MOTHER 14. Maiden Name Annie Myers

MOTHER 15. Birthplace Wilmington, N.C.

16 (a) Informant Edward Pope Small

(b) Address 1053 W. Fairmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Wilmington, N.C.

18 (a) Funeral director Wm. Gilbert Faulkner

(b) Address 631 Orleans St.

19 (a) (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

JUL 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-7-45 at 2 A. M.

(b) Where did injury occur? In front of 1040 W. Fairmount Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Shooting

23. Signature Robert Lee Graham M.D. (Medical Examiner.)

Date signed July 7, 1945.

X

G30603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G30603 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2453 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2453 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenia Roye Hardy

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Henry Hardy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	9 22	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Roye
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Elizabeth H. Waddy
(b) Address 2453 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director George W. Gallard
(b) Address 628 Druid Hill Ave

JUL 10 1945 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 7.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945 to July 5 1945, and that I last saw her alive on July 5 1945.

Immediate cause of death Intestinal Obstruction

Duration

Due to

Due to

Other Conditions Hypertensive C-V disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reynold B Lightston M. D.
Address 2129 Druid Hill Ave. Date signed 7/10/45

VS 150

122B

G30604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G30604

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N. Mount St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N. Mount St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Wimbush Tyles

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widowed

6 (b) Name of husband or wife Charles Tyles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Henderson, N.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name ?
13. Birthplace N.C.

MOTHER
14. Maiden Name ?
15. Birthplace N.C.

16 (a) Informant Mrs. Ethel Smith
(b) Address 1631 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cemetery
Location Annapolis Anne County

18 (a) Funeral director Joseph A. Lively
(b) Address 1419 N Mount Street

19 (a) (Date rec'd by registrar) JUL 10 1945 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1945, to July 9 1945, and that I last saw her alive on July 5 1945.

Immediate cause of death	Duration
Paranalytmatous nephritis	7
Due to	
Due to	
Other Conditions Anuria	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard, M.D.
Address 1631 W Franklin Date signed 7/9/45

X

G30605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G30605 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N Calhoun ST.
(c) Hospital or institution: Franklin Square Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Pierce STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Wood

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-7393

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife Cora Wood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 24 1902

8. AGE: Years	Months	Days	If less than one day
42	10	13	12 hr. 0 min.

9. Birthplace BRENTWOOD, MARYLAND (Town, county, and state)
10. Usual Occupation TRUCK DRIVER
11. Industry or business

FATHER
12. Name Richard Wood
13. Birthplace BRENTWOOD, Md.

MOTHER
14. Maiden Name Sophia
15. Birthplace BRENTWOOD, Md.

16 (a) Informant
(b) Address 1713 Pierce STREET

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore County

18 (a) Funeral director Joseph A. Bibby
(b) Address 1 Huntington Ave Williamsport, Md.

19 (a) JUL 10 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 1945, at 11 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1945 to 7-7 1945, and that I last saw h. alive on 7-7 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to gastric hemorrhage	
Due to recurrent gastric ulceration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H K Kerzner M. D.
Address Franklin Sq. Hosp. Date signed 7-8-45

VS 150

G30606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30606 Registered No. 137a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore (Govans)
(c) City or town Baltimore (Govans)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 East Melrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Oliver Sellman Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife Mrs Mary E. Anderson
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 3, 1873

8. AGE: Years 72 | Months 1 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Wholesale Shoe business

11. Industry or business

FATHER
12. Name Henry Sellman Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Sydnor
15. Birthplace Maryland

16 (a) Informant Mr. Edwin O. Anderson
(b) Address Chicago, Ill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John D. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

JUL 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 1.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1945 to 7-9 1945 and that I last saw him alive on 7-9 1945

Immediate cause of death Cardiac failure following operation for Benign Prostatic hypertrophy — Duration

Due to Arteriosclerotic and Hypertensive Cardiovascular Disease

Due to

Other Conditions Left direct Inguinal hernia

(Include pregnancy within 3 months of death)

Date of operation July 7, 1945

Major findings of operation: Enlarged prostatic gland

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, Jr. M.D.
Address Union Memorial Hospital Date signed 7/10/45

VS 150

G306607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G306607 111a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Dogwood Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles T Rumple

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rae
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Mary
15. Birthplace Penn.

16 (a) Informant Mrs Rae Rumple
(b) Address 34 Dogwood Drive

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Pattersville, Pa.

18 (a) Funeral director John O. Mitchell Funeral Inc.
(b) Address 6909 Eastern Place

19 (a) JUL 10 1945 Huntington Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1945 to 7/9 1945, and that I last saw him alive on 7/9 1945.

Immediate cause of death Acute Gastric Dilatation — Duration

Due to

Due to

Other Conditions Pulmonary Embolism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Lee M.D.
Address 34 Dogwood Drive Date signed 7/9/45

118

VS 150

JL G30608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G30608 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 Ann St. 5.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1876

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nathan Abrams
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie ?
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director Frank H Bartz
(b) Address 814 N 36 St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1945, to July 9 1945, and that I last saw her alive on July 9 1945

Immediate cause of death Cerebral hemorrhage — Duration 5 days

Due to arteriosclerosis & Hypertension — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan
Address Balt. City Hospitals Date signed 7-9-45 M. D.

G30609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G30609 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Chesapeake St.
(If rural give location)
(e) Citizen of foreign country? not (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura Irene Fielding

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: * * *
6 (c) If alive, give age * years
7. Birth date of deceased (mo., day, yr.) July 10 - 1900
8. AGE: Years 44 | Months 11 | Days 27 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Daniel J. Fielding
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Laura J. Hinder
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Edw. F. Kahl
(b) Address 59 Berkshire Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Marie
Location Towson

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt Royal Ave

19 (a) JUL 12 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1945 to July 7 1945 and that I last saw h.r alive on July 4 1945.

	Duration
Immediate cause of death: Overwhelming infection	6 days
Due to: Appendicial abscess	6 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 7/5/45
Major findings of operation: Appendicial abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Milton Linthicum M. D.
Address Date signed

VS 150

X

G30610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30610 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 Westwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Westwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. WAGAMAN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-10-5213

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hazel M. Wagaman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1902

8. AGE: Years 42 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Chambersburg, Pa.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Western Md. R. R.

FATHER
12. Name Charles W. Wagaman
13. Birthplace Chambersburg, Pa.

MOTHER
14. Maiden Name Emma E. Rice
15. Birthplace Chambersburg, Pa.

16 (a) Informant Mrs. Hazel M. Wagaman
(b) Address 2926 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1945 at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 8 1945 and that I last saw h— alive on July 8 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 3 yrs?

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jean Ashman M. D.
Address 120 Poplar Grove St Date signed 7-9-45

X Ashman

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30611 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 316 Diamond St.

(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 316 Diamond St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-1885

8. AGE: Years	Months	Days	If less than one day
60.		23	hr. min.

9. Birthplace Essex Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name

13. Birthplace Unknown

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Beverly Shaw

(b) Address 316 Diamond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cemetery

Location Balto. md.

18 (a) Funeral director William a. Jackson

(b) Address 916 Penn. Ave

19 (a) Date received by registrar 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 5. AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1943 to July 9 1945 and that I last saw h.e alive on July 1 1945

Immediate cause of death Cardio-Respiratory failure — Duration

Due to Aortic Aneurysm & Aortic Insufficiency

Due to Syphilis Hypertension, Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Meuland E. Day M. D.

Address 2734 St Paul St Date signed Jan 19, 1946

X

G30612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G30612

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marbon Apts (If rural give location)
(e) Citizen of foreign country? Married or Wdg or No) If yes, name country

3 (a) FULL NAME BEEUWKES, GERTRUDE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife C. John Beeuwkes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/1881

8. AGE: Years 63 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jacob Brown
13. Birthplace Germany

MOTHER 14. Maiden Name Hannah Stern
15. Birthplace Germany

16 (a) Informant Mr. Jr. Charles Rutherlet
(b) Address 1504 First Nat. Bank Bldg.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7/10/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frd. Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (Date received by local registrar) (b) Registrar

JUL 10 1945

Huntington Mitchell

Approved:

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9- 1945 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 9 1945 and that I last saw her alive on July 9 1945.

	Duration
Immediate cause of death Coronary occlusion (right) Ic Myocardial infarction, acute	2 hrs.
Due to arteriosclerotic + Hypertensive Heart disease	? 10 yrs.
Due to Congestive Heart failure	6 days.
Other Conditions Fracture of right patella	6 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Fractured patella

of autopsy: Myocardial infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 2, 1945 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no (Specify type of place)
(e) Means of injury Fall to floor

23. Signature Bertha Kidder M. D.
Address Sinai Hospital Date signed 7/9/45

Approved: Robert Lee Fratkin M.D. 7/13/45

G30613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 hr.
(e) Length of stay in Baltimore (yrs., mos., or days): 4 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Reisterstown Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Barbara A. Leppo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 6/29/45

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace: Reisterstown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Raymond H. Leppo
13. Birthplace: Hempstead Md

MOTHER
14. Maiden Name: Lula L Bosley
15. Birthplace: Maryland

16 (a) Informant: Mr Upton
(b) Address: Hampstead, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-46 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Cowell Rd Md

18 (a) Funeral director: Edw S Upton
(b) Address: Hampstead Md

19 JUL 10 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/9 1945 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1945 to 7/9 1945 and that I last saw her alive on 7/9 1945

Immediate cause of death: pachymeningitis — Duration: 1 wk

Due to

Due to

Other Conditions: dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: pachymeningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John P Doenges M.D.
Address: University Hosp. Date signed: 7/10/45

VS 150

G30614

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G30614
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mo21da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Abbott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COL.	Wid.

6 (b) Name of husband or wife Edward Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name GEORGE THOMPSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CATHERINE
15. Birthplace MARYLAND

16 (a) Informant Records-us marine hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12-1945 (month) (day) (year)
(c) Cemetery or crematory Int Zion Cemetery
Location Balto Md.

18 (a) Funeral director Robt E. Williams
(b) Address 1515 McElderry St

19 (a) (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1945, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17, 1945 to July 8, 1945 and that I last saw him alive on July 8, 1945

Immediate cause of death	Duration
Cerebral hemorrhage with hemiplegia	4 mo.
Due to Hypertensive cardio-vascular disease	Unk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J.F. van Ackeren M.D.
Address US Marine Hospital Date signed 7/9/45
Baltimore, Maryland

G30615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30615
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Eagle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County U S A.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Eagle St.. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jno N. Goldsborough

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-1895

8. AGE: Years	Months	Days	If less than one day
50	5	4	hr. min.

9. Birthplace Balto Md.. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John W. Goldsborough
13. Birthplace Balto. Md..

MOTHER
14. Maiden Name Frances Dorsey.
15. Birthplace Balto Md.

16 (a) Informant Addie Goldsborough
(b) Address 1819 Eagle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1945 (Month) (Day) (Year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katy R Williams
(b) Address 322 N Schroeder St

19 (a) [redacted] (b) [redacted]
(Date rec'd by Registrar) Registrar

Huntington

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to 7-7 1945; and that I last saw h[redacted] alive on 7-5 1945.

Immediate cause of death
Cerebral Apoplexy
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
9 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Waters
Address 1225 Pa Date signed July 11 45

X

G30616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G30616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2118 Eastern Aveme
(c) Hospital or institution: 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 Eastern Aveme (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FELIKSA KOZLOWSKA

3 (b) If veteran, name war: ***
3 (c) Social Security Account No. ***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 12/12/78

8. AGE: Years	Months	Days	If less than one day
66	6	25	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Nowogrocki
13. Birthplace Poland

MOTHER
14. Maiden Name Eleanora Mosak
15. Birthplace Poland

16 (a) Informant Miss Helena Kozlowska
(b) Address 2118 Eastern Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1809 Eastern Avenue

19 (a) (Date received by registrar) (b) Registrar

JUL 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to July 7 1945 and that I last saw her alive on July 7 1945

Immediate cause of death: Aorta Coarctation — Duration: 1 day
Due to: Dilatation — 1 yr.
Due to: Mitral Regurgitation — about 3 yrs.
Due to: Chronic Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Szymbrich M.D.
Address 1802 Eastern Ave Date signed 7-9-45

VS 150

G30617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 932

G30617 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs. 10
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Lawrence (Mary Brunner)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1864

8. AGE: Years	Months	Days	If less than one day
81	3	23	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business Teacher

FATHER
12. Name Frank Joseph Brunner
13. Birthplace Margaret Werner

MOTHER
14. Maiden Name Bavararia Germany
15. Birthplace Bavaria Germany

16 (a) Informant Sisters of Notre Dame
(b) Address 901 Aisquith Street

17 (a) July 13 (b) Date thereof 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Govans

18 (a) Funeral director Geo. M. Stuart & Son
(b) Address 811 W. Lafayette Ave

19 (a) (b) Huntington Mikesell, M.D. Registrar

VS 10348

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 5.20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1935 July 10 1945, and that I last saw h[illegible] alive on July 9 1945.

Immediate cause of death
Myocardial degeneration with
Due Decompensation
Due to Generalized Arteriosclerosis

Duration
10 Yrs
20 Yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Straight M.D.
Address 10 E. Biddle St Date signed July 10 1945

Lenare #11

G30618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G30618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY JUL 7 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1945, at 11 AM

21. I certify that I took charge of the remains described above, held an Inquisition o Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury June 25 1945 at 3/27 M.
(b) Where did injury occur? Herbert foot of Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Found Drowned

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed June 27 1945

VS 151

X

G30619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30619

Registered No. 46M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Saratoga & Calvert Sts.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Severn

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Grace Gardner Watts

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife S. Samuel Watts

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1893

8. AGE: Years	Months	Days	If less than one day
51	9	4	hr. min.

1893

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Solon Gardner

13. Birthplace Maryland

MOTHER

14. Maiden Name Leanna Gardner

15. Birthplace Maryland

16 (a) Informant S. Samuel Watts

(b) Address Gambrills, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12/45 (month) (day) (year)

(c) Cemetery or crematory Calvary Gardens

Location Gambrills Md.

18 (a) Funeral director B. L. Hopkins

(b) Address Annapolis Md.

19 (a) (Date rec'd by registrar) (b) JUL 10 1945 Huntington Williamsport, Md.

VS 1a

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 9 1945, and that I last saw h[illegible] alive on July 9 1945

Immediate cause of death	Duration
Secondary hemorrhage from gastro-intestinal tract	4 hrs.
Due to Malignancy of G-I tract	
Due to	
Other Conditions Resection of Sigmoid flexure - 5/5/45 (Include pregnancy within 3 months of death)	

Date of operation 5-5-45

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. Milton Linthicum M. D.

Address Date signed

G30643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30620

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Vine

(If outside city or town limits, write RURAL and give town)

(d) Street No. 663 Vine St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lee Trent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Separated

6 (b) Name of husband or wife Katie B. Trent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/26/911

8. AGE: Years	Months	Days	If less than one day
33	11	10	hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name John Trent

13. Birthplace N C

MOTHER

14. Maiden Name Mary ?

15. Birthplace N C

16 (a) Informant Katie B. Trent

(b) Address 663 Vine st

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Pennsylvania Ave

19. JUL 10 1945 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 3 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1945 to 7-6 1945, and that I last saw him alive on 7-6 1945.

Immediate cause of death Respiratory failure (Labar Pneumonia)

Duration

Due to Pneumonia (labar)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. D.

Address 1514 Division St Date signed 7/10/45

VS 180

G30621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G30621 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 E. 30th St.
(c) Hospital or institution: 9-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD P. GALLAGHER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-4342

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Cecilia T. Gallagher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1867

8. AGE: Years	Months	Days	If less than one day
78	4	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant Miss Cecelia L. Gallagher
(b) Address 1811 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 10 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12, 1942 to July 9, 1945, and that I last saw him alive on July 9, 1945.

Immediate cause of death	Duration
Acute myocardial failure	1 hour
Due to Arteriosclerosis	Unknown
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. B. Sybert M. D.
Address 2807 Harford Rd Date signed 7/10/45

VS 150

G30622 G30622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 57413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos. 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Wisconsin (b) County
(c) City or town Kenosha (If outside city or town limits, write RURAL and give town)
(d) Street No. 4506 5th Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Martin Engel Engelson (E. Martin Engelson)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred Engelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	2	hr. min.

9. Birthplace Chicago, Illinois (Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafaring

FATHER
12. Name Torger Engelson
13. Birthplace Norway

MOTHER
14. Maiden Name Anna Opdahl
15. Birthplace Norway

16 (a) Informant Mrs. Mildred Engelson
(b) Address 4506 -5th Ave., Kenosha, Wisc.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/10/45 (month) (day) (year)
(c) Cemetery or crematory Greenridge Cem.
Location Kenosha, Wisc.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar JUL 10 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1945 to July 10 1945, and that I last saw him alive on July 10 1945.

Immediate cause of death Carcinoma of the sigmoid colon — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Exploratory lap. 3/3/45 4/3/45
Major findings of operation: Colostomy 3/3/45 4/3/45
of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/10/45

(over)

Baltimore 11, Maryland.

G30623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30623

Registered No. 59884

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 mo 21 days

(e) Length of stay in Baltimore (yrs., mos., or days): 19 yrs 7½ mos

2. USUAL RESIDENCE OF DECEASED:

(a) State: New Jersey (b) County:

(c) City or town: Fairview (If outside city or town limits, write RURAL and give town)

(d) Street No.: 313 Third Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country:

3 (a) FULL NAME: John Dutko

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: 143-12-5563

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Alice Dutko

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 1, 1893

8. AGE: Years	Months	Days	If less than one day
51	7	8	hr. min.

9. Birthplace: ? Russia (Town, county, and state)

10. Usual Occupation: Deckhand

11. Industry or business: Seafaring

FATHER

12. Name: Tony Dutko

13. Birthplace: Russia

MOTHER

14. Maiden Name: Margalena ?

15. Birthplace: Russia

16 (a) Informant: Records, U. S. Marine Hospit

(b) Address: Baltimore 11, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/10/45 (month) (day) (year)

(c) Cemetery or crematory: Fairview Cem.

Location: Fairview, N. J.

18 (a) Funeral director: WM. J. TICKNER &SONS

(b) Address: Balto., Md.

19 (a) Filed 0 1945 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

(b) Registered

VS 150

MEDICAL CERTIFICATION

3:29 P.M.

20. DATE OF DEATH: July 10 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 1945 to July 10 1945, and that I last saw him alive on July 10 1945.

Immediate cause of death	Duration
Carcinoma of the larynx	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson M. D.

Address: U.S. Marine Hospital Date signed 7/10/45

(over)

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G30624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Kenyon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Kenyon Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Poland

3 (a) FULL NAME Cecilia Stefanski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas Stefanski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1872

8. AGE: Years	Months	Days	If less than one day
72	8	14	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name ? Wozniak
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Mikulski
(b) Address Decker ave and Fleet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location German Hill Road

18 (a) Funeral director John M. Weber
(b) Address 402 S. Chester St.

19 (a) (Date rec'd by registrar) Huntington-Williams M.F.

JUL 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1945, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1943 to July 7 1945, and that I last saw her alive on July 7 1945.

	Duration
Immediate cause of death Hypertension	
Arteriosclerosis C.V. Disease.	
Cerebral Hemorrhage	5-3-45
Due to Myocardial Failure	7-4-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Simunek M. D.
Address 842 S. East Ave Date signed 7-9-45

X

G30625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30625 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 13 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emelie C. Siegmund

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Widowed

6 (b) Name of husband or wife Gustave Siegmund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1845

8. AGE: Years	Months	Days	If less than one day
92	10	16	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Hackmann
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Bohne
15. Birthplace Germany.

16 (a) Informant Home for Incurables
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director E. Miller Lamotte
(b) Address 410 Liberty Heights Ave

JUL 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/26 1945 to 7/9 1945, and that I last saw h[illegible] alive on 7/7 1945.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	6 months
Due to Arteriosclerosis (Generalized)	20 years
Due to Hypertension (Essential)	10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergesheimer
Address 214 Medical Arts Bldg Date signed 7/9/45

VS 8

G30626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

Registered No. G30626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Maryland General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3606 Ferndale Ave. #7 (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert C. Shiflet (Albert C. Shiflet)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irene M. Shiflet

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 14, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	24	hr. min.

9. Birthplace Washington County, Md. (Town, county, and state)

10. Usual Occupation Boiler Inspector

11. Industry or business Pennsylvania R. R.

FATHER 12. Name Thomas J. Shiflet

13. Birthplace Washington County, Md.

MOTHER 14. Maiden Name Anna Myers

15. Birthplace Washington County, Md.

16 (a) Informant Mrs. Irene M. Shiflet

(b) Address 3606 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1945 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem.

Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso

(b) Address 4520 Liberty Heights Ave.

19 (a) (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

JUL 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1945 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945, to July 8 1945, and that I last saw him alive on July 8 1945.

Immediate cause of death	Duration
Peripheral Circulatory Failure	
following Hemorrhage	
Due to Ruptured peptic ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/17/45

Major findings of operation: Ruptured ulcer (Gastric)

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Martin E. Strobel M. D.

Address Md. Gen'l. Hospital Date signed 7/8/45

Form 10 Rev. 1945 (Duplicate)

G30627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G30627 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Old Orchard Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Old Orchard Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Heavey HEAVEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mary Regina nee Kessler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1879

8. AGE: Years	Months	Days	If less than one day
66	4	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Supt Premium Income
11. Industry or business Fidelity & Deposit

FATHER
12. Name James F. Heavey
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Heavey
15. Birthplace Ireland

16 (a) Informant Mrs Mary Heavey
(b) Address 519 Old Orchard Rd

17 (a) Burial (b) Date thereof 7-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location 3700 Old Frederick Rd

18 (a) Funeral director Harry A Wilke
(b) Address 1101 E Monument Baltimore

19 (a) JUL 10 1945 (b)
(Date rec'd by registrar) Thurlington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 6.40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to July 8 1945 and that I last saw him alive on July 8 1945

Immediate cause of death — Duration

Myocardial Failure 10 Mos.

Due to Cardio Vas - Renal Disease 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. Van Schaick Mumford M.D.
Address 1415 Eutaw Place Date signed 7/9/45

G30628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Gwynn Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Catherine Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5 1870

8. AGE: Years	Months	Days	If less than one day
75	9	4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George C. Turner
13. Birthplace Baltimore

MOTHER 14. Maiden Name Katherine Eckard
15. Birthplace Baltimore

16 (a) Informant Harry E. Theed
(b) Address 3406 Gwynn Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1945 (month) (day) (year)
(c) Cemetery or crematory London
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts.

19 (a) JUL 11 1945 (Date received) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945 to July 9 1945 and that I last saw her alive on July 7 1945.

Immediate cause of death	Duration
Myocarditis about	6 mo
Due to	
advanced arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Hallie S. Turbitt, M.D.
Address 2220 Garrison Blvd. Date signed 7/10/45

G30629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30629

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Kingston Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Kingston Rd.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Harry M. Rever

3 (b) If veteran, name war: ****

3 (c) Social Security Account No. 218-10-0614

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Widowed

6 (b) Name of husband or wife Julia E. Rever

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1868

8. AGE: Years	Months	Days	If less than one day
77	4	27	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Sherwood Bros. Inc.

FATHER
12. Name Ferdinand A. H. Rever
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmena Humicon
15. Birthplace Germany

16 (a) Informant Mrs. Laura E. Bethke
(b) Address 505 Kingston Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) 1111 7-11-1945 (Registrar's signature) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945, at 5:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1945, to July 9, 1945, and that I last saw h[illegible] alive on July 9, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Arteriosclerosis	2
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Pennington, M. D.
Address 514 Druid Park Lane Date signed 7/9/45

X

A41962 G30630 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G30630

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Morgantown (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 126-Rt-5 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Danny A. Groves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-26-45

8. AGE: Years	Months	Days	If less than one day
	2	14	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER
12. Name Guy Groves
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Dodge
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory Terra Alta
Location Terra Alta, W. Va.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 — 1945 at 5 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2- 1945 to 7-10- 1945 and that I last saw h[illegible] alive on 7-10- 1945.

Immediate cause of death Congenital Malformation of Heart — Duration —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rowena A. Hall Asst Res.
Address Hopkins Hospital Date signed 7-10-45 M. D.

VS 150

X

G30631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16 1 C

Registered No. G30631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Deboy Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roy Lee Minnick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1945

8. AGE: Years	Months	Days	If less than one day
		4 days	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Minnick
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Wood
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 11 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 12:35 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945, to July 3 1945, and that I last saw him alive on July 3 1945.

Immediate cause of death	Duration
erythroblastosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J Vosburgh M. D.
Address Johns Hopkins Hospital Date signed 7-5-46

VS 150

12824

G30632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2954 Sollers Point Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Howard Sanders
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Ethel Hewitt
15. Birthplace: Pennsylvania

16 (a) Informant: Hospital Records
(b) Address: Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: JOHN HOPKINS MEDICAL SCHOOL JUL 10 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

JUL 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 6 1945, and that I last saw him alive on July 6 1945.

Immediate cause of death: Anoxia Exhaustion — Duration
Due to: ? Laryngeal Obstruction
Due to: ? Trauma
Other Conditions: Prematurity
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert J. Vosburgh M. D.
Address: Johns Hopkins Hospital Date signed 7-7-45

VS 150

12823

G30633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G30633

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3713 Clarks Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel J. Hamburger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Julia nee Rumbo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual Occupation Credit Manager

11. Industry or business

FATHER 12. Name Harry

13. Birthplace Russia

MOTHER 14. Maiden Name Ida

15. Birthplace Russia

16 (a) Informant Julia Hamburger

(b) Address 3713 Clarks Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)

(c) Cemetery or crematory Beth Jacob

Location Windsor Mill Road

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto. St.

1945 7 11 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 5:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 10 1945, and that I last saw him alive on July 10 1945.

Duration
24 hrs.
24 hrs.
24 hrs.
24 hrs.

Immediate cause of death Cardiac failure

Due to Surgical shock and internal hemorrhage

Due to Gastric resection

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 9, 1945

Major findings of operation: Tumor gastric antrum.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Herbert Chernin, M.D.

Address Sinai Hospital Date signed 7/10/45

M. D.

VS 150

G306534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G306534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Weaver Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Weaver Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS FERDINAND EINWACHTER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida G. Einwachter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1893

8. AGE: Years	Months	Days	If less than one day
51	8	14	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Balto. City Jail

FATHER
12. Name Adam Einwachter
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Ida G. Einwachter
(b) Address 3106 Weaver Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/ /45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945, at 12:30 M A.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 10 1945 and that I last saw her alive on July 10 1945

Immediate cause of death: Coronary Occlusion — Duration 1/2 hour

Due to:

Due to:

Other Conditions: Hypertension — 10 years

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operations: ns

of autopsy: ns

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ns
(b) Date of occurrence none at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Coronary and M. D.
Address 5106 Liberty Rd. Date signed 7/10/45

G 0535

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 5-0 Registered No. G 30535

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts.
(c) Hospital or institution: Univ. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 Linden Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Lippert
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-01-2566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Carrie C. Lippert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 20, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Eastman Kodak Co.

FATHER 12. Name Peter Lippert
FATHER 13. Birthplace Germany Bavaria

MOTHER 14. Maiden Name Annie Sabella Lippert
MOTHER 15. Birthplace Germany

16 (a) Informant Ruth M. Handt
(b) Address 900 Leah Ave, Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 12 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Wm. J. Tydeven & Sons
(b) Address Balto., Md.

19 (a) 7 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1945 to July 10 1945, and that I last saw him alive on July 10, 1945

Immediate cause of death	Duration
Cancer	
Due to	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy L. Alta, Jr. M. D.
Address Univ. of Md. Hosp. Date signed 7/10/45

VS 150

X

G30636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G30636

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Queen

3 (b) If veteran, name war: World War # 2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Shirley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 19, 1920

8. AGE: Years: 25 | Months: 8 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Harry Queen
13. Birthplace: Md.

MOTHER
14. Maiden Name: Marie ?
15. Birthplace: Md.

16 (a) Informant: Shirley Queen
(b) Address: 1408 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 12/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem.
Location

18 (a) Funeral director: Mrs. Robert A. Elliott
(b) Address: 1129 N. Carrollton Ave.

19 (a) 7 11 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9, 1945, at 3 40 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of Skull; Multiple Fractures, ? Ribs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 9/9

(a) Date of injury 7-9-45 at 12:30 P. M.
(b) Where did injury occur? Federal & Eden Sts.
Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(c) Means of injury: Collision of auto. and truck - fire fighting

23. Signature: Leland C. Gratacap M.D.
Medical Examiner.
Date signed: July 9 1945

VS 151

330346 G30637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

Registered No. G30637

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 50 | Months | Days | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Anthony Dixon
13. Birthplace Md.

MOTHER
14. Maiden Name Linnie Denby
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore - Md

18 (a) Funeral director Jesse W. Reddick
(b) Address 43 So W. Biddle St

19 (a) (b) Huntington Williams, M.D.

JUL 11 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 - 1945, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26-1945 to 7-9-1945 and that I last saw her alive on 7-9-1945.

Immediate cause of death Carcinoma of the Cervix. — Duration

Due to

Due to

Other Conditions Hydronephrosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph R. Stanton M. D.
Address Hygeia Hosp. Date signed 7-9-45

X

30637½

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 67

Registered No. 6-30637½

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S. Sparrow Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1945

8. AGE: Years	Months	Days	If less than one day
—	2	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wilbert Chinchow
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Moore
15. Birthplace Md.

16 (a) Informant Birth Certificate
(b) Address 2496 2

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1945 at 3 o. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Scurvy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Yeatman M.D. Medical Examiner.
Date signed July 13 1945

VS 151

G30638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G30638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Provident.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 883 Tyson St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6 1883

8. AGE: Years 62 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business

FATHER 12. Name Cachie Tyler

13. Birthplace Va

MOTHER 14. Maiden Name Josephine Thompson

15. Birthplace

16 (a) Informant Paie C. Tyler

(b) Address 883 Tyson St.

17 (a) Burial (b) Date thereof July 11 - 45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) (b) Registrar

(Must be read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 8:5 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to July 8 1945, and that I last saw him alive on July 8 1945.

Immediate cause of death	Duration
Carcinoma of Liver	3 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Edward Higgins M. D.

Address 913 Madison Ave Date signed 7-9-45

VS 150

G 42-22

G30639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G30639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Yurham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1941

8. AGE: Years	Months	Days	If less than one day
4	3	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Yurham
13. Birthplace ?

MOTHER
14. Maiden Name Rush ?
15. Birthplace ?

16 (a) Informant Uncle
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945 at 4 13 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 8 1945 and that I last saw him alive on July 5 1945

Immediate cause of death	Duration
Cong Heart Defect	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton D Gordon Jr M.D.
Address JHH Date signed 7/9/45

VS 150

G30640 — BALTIMORE CITY HEALTH DEPARTMENT — G30640

CERTIFICATE OF DEATH 132

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Penna. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel McCray Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Joseph Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1902

8. AGE: Years 43 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Rockingham, N.C. (town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER — 12. Name Sim McCray

13. Birthplace Rockingham, N.C.

MOTHER — 14. Maiden Name Cheele Bloomfield

15. Birthplace ? N.C.

16 (a) Informant Sarah McCray

(b) Address 1105 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945, at 9:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26, 1945, to July 7, 1945, and that I last saw ~~her~~ alive on July 7, 1945

Immediate cause of death: Uremia — Duration: 2 days

Due to: Anuria — 3 days

Due to: Bright's Disease — 6 mo.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature [signature]
Address Provident Hospital Date signed 7/10/45 M. D.

VS 150

G30641 G30641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 N. Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Harry L. Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1885

8. AGE: Years	Months	Days	If less than one day
59	11	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace ?

16 (a) Informant Harry L. Bond
(b) Address 523 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-45 (month) (day) (year)
(c) Cemetery or crematory Antrim
Location Balto. Co.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Wilson St.

19 (a) (b) Registrar
Certificate received for registration

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 1945 at 6 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1945 to 7-5 1945
and that I last saw h alive on 7/5 1945

Immediate cause of death Chronic Cardiovascular Renal Disease

Due to Pulmonary Edema Hypostatic pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7 Mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 600 Arlington Ave Date signed 7/10/45

X

G30642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G30642 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Catoa & Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1602 Warwick ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Albert Wunder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26 1881

8. AGE: Years 64 | Months 1 | Days 16 | If less than one day hr. min. 15

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Caulker

11. Industry or business

FATHER 12. Name John Wunder

13. Birthplace Md

MOTHER 14. Maiden name Mary Rothfuss

15. Birthplace Md

16 (a) Informant Mrs Minnie Wunder

(b) Address 1602 Warwick Ave Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Balto Md

18 (a) Funeral director George G Fuller

(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Interment Wilmington Del

VS 188 JUL 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1945, at 855 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1945 to 7/9 1945, and that I last saw h alive on 7/9 1945

Immediate cause of death Acute Cardiac Dilatation & Pulmonary Edema (Post Operative)

Due to Carcinoma of the stomach & metastasis.

Due to

Other Conditions Bil. Inguinal Hernia Hypertrophy Prostate

(Include pregnancy within 3 months of death)

Date of operation 7/7/45

Major findings of operation: Ca Stomach & metastasis

of autopsy: Ca above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert B McFadden M. D.

Address St Agnes Hosp. Date signed 7/11/45

A42162
G30643

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G30643
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Langley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/5/45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Langley
13. Birthplace Md

MOTHER
14. Maiden Name Ella Bates
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 4304 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JUL 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 - 1945 at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to 7-10- 1945, and that I last saw him alive on 7-10- 1946

Immediate cause of death: Bilateral Pneumonia — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena D. Hall Ousley M.D.
Address Hopkins Hospital Date signed 7-10-45

X

G30644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G30644 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1566 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1566 Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Quill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 / 91

8. AGE: Years	Months	Days	If less than one day
55 53	2	-	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Alberta Wilson
(b) Address 1566 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Leg. L. Kelly
(b) Address 303 Preston and St

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 10 1945 and that I last saw h[illegible] alive on July 10 1945.

Immediate cause of death Lobar Pneumonia — Duration 10 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. William Frey M.D.
Address 1928 Penna Ave Date signed 7/11/45

X

G30645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G30645 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 742 Poplar Grove St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 742 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellanora Williams

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George K. Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 3. 1880

8. AGE: Years 65 | Months 3 | Days 6 7 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Cornelius F. Williams
13. Birthplace Va.

MOTHER 14. Maiden Name Virginia Anderson
15. Birthplace Va.

16 (a) Informant Florence V. Timmins
(b) Address 742 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. Mrs. John N. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

JUL 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1945 to July 10 1945, and that I last saw h alive on July 10 1945

Immediate cause of death: Cardiac Failure — Duration: 1 da

Due to Carcinoma of Breast — Duration: 5 yr

Due to cancer Johns Hopkins Hosp — Duration: 6 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Florence V. Timmins
Address 1202 St Paul St Date signed 7/10/45 M. D.

630646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

630646

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) D.O.A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Elmley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BEVERLY JANDA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1943

8. AGE: Years	Months	Days	If less than one day
2	2	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Janda
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anne Svehla
15. Birthplace Baltimore

16 (a) Informant William Janda
(b) Address 3209 Emley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore, Md.

18 (a) Funeral director Frank Ovach & Son
(b) Address 900 N. Chester St.

19 (a) JUL 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945 at 8:40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-9-45 8: P. M.
(b) Where did injury occur? In the rear of 1916 Wilson Pt., Middle River.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Robert L. Gratton M.D. Medical Examiner.
Date signed July 10 1945

VS 151

G30647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30647 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 N. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA WITTMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Edward Wittman (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1867

8. AGE: Years	Months	Days	If less than one day
78 yrs.	-	22	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Helene Devine
(b) Address 531 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Phila. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 1945 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1945 to July 8 1945, and that I last saw h er alive on July 8 1945

Immediate cause of death	Duration
(a) Cardiac Dilatation	4 hrs
Due to (b) Chr. Myocarditis	10 years
Due to (c) —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Harding M.D.
Address 4810 Belair Rd Date signed July 10/45

VS 180

X

G30648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30648 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Edmondson ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna C. Leer.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Late Wm J Leer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6. 1867

8. AGE: Years	Months	Days	If less than one day
78	3	2.	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation –

11. Industry or business –

FATHER
12. Name John Liere
13. Birthplace Unknown.

MOTHER
14. Maiden Name Kate Theye.
15. Birthplace Maryland.

16 (a) Informant Charles F. Uhlenberg
(b) Address 224 N Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave.

18 (a) Funeral director Harry H Witzke
(b) Address 1101 Edmondson ave.

19 (a) JUL 11 1945 (Date rec'd by registrar) (b) Timothy Tom Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8. 1945. at 11 AM M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C Davis M.D. Medical Examiner.
Date signed 7/10/45

IF ANY WORD IS WRONG, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No. G30649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood st
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 551 Oxford St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Oscar Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1905

8. AGE: Years	Months	Days	If less than one day
39	8	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jack Whillon
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Diggs
15. Birthplace Virginia

16 (a) Informant Oscar Nelson
(b) Address 551 Oxford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Geo. T. Gibson
(b) Address 1735 Druid Hill Ave.

19 JUL 11 1945 (Date rec'd by registrar) Justice for Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 11:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945, to July 10 1945, and that I last saw her alive on July 10 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Unknown-	
Due to	
Other Conditions Uterine Fibroid CA PID (Include pregnancy within 3 months of death)	
Date of operation July 10, 1945	
Major findings of operation Uterine fibroid & CA PID.	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. M. Baggett M.D.
Address Univ Hosp Date signed 7/10/45

VS 150

X

G30650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G30650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5213 Beaufort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5213 Beaufort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry V. Cease

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-0028

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 8th 1887

8. AGE: Years	Months	Days	If less than one day
58	5	2	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Roofing helper
11. Industry or business M. J. Frederick & Co

FATHER
12. Name Charles L. Cease
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary E. Gardner
15. Birthplace Baltimore, Md

16 (a) Informant Mr Clarence A. Cease
(b) Address 5213 Beaufort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial Pk
Location Gorsey Rd

18 (a) Funeral director John F. Cowan & Son
(b) Address 1103 Hollins St

19 (a) (Date rec'd by registrar) JUL 11 1945 (b) Registrar Hunting for Millard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 10 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Pancreatic Cancer	??
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harman H Gelman M. D.
Address 611 Pamlico Rd Date signed 7-10-45

X

G30651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) About 74 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Franklin Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Margaret Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------- 1871

8. AGE: Years	Months	Days	If less than one day
74	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Walsh
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine O'Brien
15. Birthplace Ireland

16 (a) Informant Jenkins Memorial Hospl
(b) Address 1000 Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 W. Calvert Street Funeral Director for Mortuary, Md.

19 (a) 7/11/1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th 1945, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 10 1945, and that I last saw her alive on July 10 1945.

Immediate cause of death	Duration
Cardiac Failure,	
Due to Cardiovascular disease	
Due to	
Other Conditions Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff. Rodaleff M. D.
Address St Agnes Hosp. Date signed 7/11/45

VS 150

G30652 — BALTIMORE CITY HEALTH DEPARTMENT — G30874

CERTIFICATE OF DEATH 92E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2823 Mathews Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 78 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Mathews Street (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME: Isabelle Vincent Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carvil S. Mason

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.): July 19, 1866

8. AGE: Years 78 | Months 11 | Days 20 | If less than one day -- hr. --- min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -----

FATHER
12. Name: James D. Ross
13. Birthplace: England

MOTHER
14. Maiden Name: Ann Wren
15. Birthplace: England

16 (a) Informant: Mrs. Isabel Stricker
(b) Address: 2825 Mathews Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19 (a) JUL 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1945, at 9 20P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1945 to 7/9 1945, and that I last saw h[er] alive on 7/7 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: about 2 yr

Due to:

Due to:

Other Conditions: Endocarditis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Geo. W. Morgan Troyd, M.D.
Address: 401 E. 25th. St. Date signed 7/10/45.

GEO. W. MORGAN TROYD.

G30653 ✗✓ G30653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co
(c) City or town Sparks
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Heath

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-28-45

8. AGE: Years ..... Months ..... Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business .....

FATHER
12. Name Charles Heath
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Widner
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 12 45 (month) (day) (year)
(c) Cemetery or crematory Jessops Methodist
Location Sparks

18 (a) Funeral director Loudon M. Brooks
(b) Address Sparks, Md.

19 (a) [illegible] (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945 at 12 20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 45 to July 11 1945 and that I last saw h[illegible] alive on July 11 1945.

Immediate cause of death Prematurity

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Rowena A. Wall Asst La
Address Hopkins Hospital Date signed 7-11-45 M. D.

VS 150

X

G30654 ✓ G30654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward's Lane 24
(c) Hospital or institution: Lemmuntry Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1862 1/2 Ct St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John W Sellman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2nd 1879

8. AGE: Years	Months	Days	If less than one day
65	10	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Mechanic.
11. Industry or business American Can Co

FATHER
12. Name Joseph Sellman
13. Birthplace Md.

MOTHER
14. Maiden Name Melinda Hatfield
15. Birthplace Md.

16 (a) Informant Mrs Harry L. Cora
(b) Address 1129 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery U. S. National
Location Balto Md

18 (a) Funeral director William Cook & Son
(b) Address 1217 St. Paul St.

19 (a) 7-12-1945 (b) (Date received by Registrar) Hennington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 10 1945, and that I last saw him alive on July 10 1945

Immediate cause of death	Duration
Acute brain damage and gastric hemorrhage.	
Due to Gastrotomy, penetrating duodenal ulcer.	
Due to Carcinoma of head of pancreas	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 29 1945
Major findings of operation: Carcinoma head of pancreas.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address Univ. Hosp. Date signed July 10 45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30655 ✓ G30655

Registered No. 13B

G30655 Th. 62445

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 -S- 8 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Durham St 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Langreher

3 (b) If veteran, name war W
3 (c) Social Security Account No. xxx

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26th. 1869

8. AGE: Years 76 | Months 1 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial, cremation, or removal Burial Date thereof 7/12/45 (month) (day) (year)
(b) Cemetery or crematory Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by Registrar) 7 12 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th, 1945 19 ..... at 11 A/M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 8th 45 19 to July 9th 19 45, and that I last saw him alive on July 9th 19 45

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pulmonary tuberculosis Generalized arteriosclerosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Rowland Jr.
Address Baltimore City Hosp. Date signed 7/10/45

VS 150

X

G30656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G30656 8/a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Lombard St.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) B Dep.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County York County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 W. Locust St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LESTER RAWKERT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18-1911

8. AGE: Years	Months	Days	If less than one day
34	4	23	hr. min.

9. Birthplace York County, Pa.
(Town, county, and state)

10. Usual Occupation Grocery Store Operator

11. Industry or business " "

FATHER
12. Name Ezra K RAWKERT
13. Birthplace PENN.

MOTHER
14. Maiden Name CORA RAUBY
15. Birthplace PENN

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof July 14-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dolfs
Location York Co. Pennsylvania

18 (a) Funeral director Burgle Funeral Home
(b) Address 3631 Dolfs Road

19 (a) (b) Registrar of
(Date rec'd by Registrar) JUL 12 1945 Washington Township, York Co., Pa.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to July 11 1945, and that I last saw him alive on July 11 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 29, 1945

Major findings of operation: Uremia meningitis

of autopsy: Uremia meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence G. Brown M. D.
Address Union. Hosp. Date signed 7/11/45

X

G30657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G30657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 218 N. Wolfe Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1889

8. AGE: Years	Months	Days	If less than one day
56	4		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant MYRTLE WADDELL
(b) Address 1704 E. CHASE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location

18 (a) Funeral director ELROY D. WILSON
(b) Address 1000 GRANTLEY AVE.

19 (a) JUL 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 45 19 4:15 at A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebro vascular
Cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutman M.D. Medical Examiner.
Date signed July 7, 1945.

VS 151

630638 ✓ 630638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 236 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 236 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Tolas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife James Tolas (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1894

8. AGE: Years 51 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace West morland Co. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Smith
13. Birthplace Va.

MOTHER 14. Maiden Name Parcilla Smith
15. Birthplace Va.

16 (a) Informant Hattie Jackson
(b) Address 233 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945 at 4:15 AM 7/10/45

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1945, to July 14, 1945, and that I last saw [illegible] alive on July 14.

Immediate cause of death Myocardial Degeneration, Cardiac Renal Disease — Duration 7

Due to

Due to

Other conditions Bronchopneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mabel Olson, M. D.
Address 312 E 23rd St Date signed 7-11-45

Filed JUL 12 1945 Huntington Williams, M.D. Registrar

VS 150

X

G30559 X ✓ G30659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 56E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Talbot
(c) City or town: Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: H. SKIPWITH GORDON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: wh.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: MARTHA E GORDON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 25, 1868

8. AGE: Years 76 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace: Easton, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: H. Skipwith Gordon
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Elizabeth Wheeler
15. Birthplace: Balto., Md.

16 (a) Informant: Mr. H. Skipwith Gordon, Jr.
(b) Address: 7114 Ridgehill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory: Spring Hill Cem.
Location: Easton, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1945, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1945, to 7-11-1945, and that I last saw h[illegible] alive on 7-11 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to uremia	
Due to bladder tumor — papilloma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Richard D. Hoover M. D.
Address: Univ. Hosp. Date signed 7/14/45

X

G30660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G30660 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Park Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Ruth Jordan

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Russel C. Jordan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1910

8. AGE: Years 34 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: John Patrick Kenny
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Margaret L. Pomiebozemsky
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Margaret L. Kenny
(b) Address: 2243 Orem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams M.D.

JUL 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945, at 6 25 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Contusion of Brain
Purulent meningitis, traumatic

Due to

Other Conditions Pulmonary Tuberculosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/29/45 at M.
(b) Where did injury occur? 514 Park Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Blunt Force

23. Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed July 11 1945

AB-93170 G30653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1862 V G30653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1820 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorothea Yingling

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles H. Yingling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1852

8. AGE: Years	Months	Days	If less than one day
92	8	24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Carl Fraska (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Gesine ? (D)
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Name rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9- 1945, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-17- 1945, to 7-9- 1945, and that I last saw h[illegible] alive on 7-9- 1945.

Immediate cause of death: Congestive heart failure — Duration: ?

Due to:

Due to:

Other Conditions: fracture neck of left femur. — Duration: 4½ mos.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence late in Feb. 1945 at M
(c) Where did injury occur? 1820 N. Monroe St. Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) Did it occur at work? No.
(e) Means of injury Fell in home

23. Signature Frank E. Bolton
Address Balt. City Hosp. Date signed 7/11/45 M.D.

TO BE APPROVED BY MEDICAL EXAMINER Approved: Robert Lee Graham M.D.

G30662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30662 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp. 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Abell ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Shea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Hoch L. Shea

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1884

8. AGE: Years	Months	Days	If less than one day
61	2	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John J. Roddy
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Naughton
15. Birthplace Ireland

16 (a) Informant Hoch L. Shea
(b) Address 3116 Abell Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. E. Evans & Son
(b) Address 1 W. Mt Royal Ave

19 (a) JUL 12 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1945 to 7-11 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 7-11-45

Huntington Williams, M.D.

VS 180

83a

G30563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G30563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie May Evan nee Dickson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widow

6 (b) Name of husband or wife Edward Lee Evan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12.12.1884

8. AGE: Years	Months	Days	If less than one day
60	6	29	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name Albert Dickson
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Alice Allen
15. Birthplace unk.

16 (a) Informant Albert Dickson
(b) Address 112 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-45 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem't, Location Baltimore, Md

18 (a) Funeral director Moore & Bailey
(b) Address 1421 E. Jefferson St.

19 (a) (Date received by registrar) 7-14-1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1945, at 7 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1945 to 7/10 1945 and that I last saw h.. alive on 7/6 1945

Immediate cause of death	Duration
pulm. tuberculosis	unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raymond Brownlee, M.D.
Address 1500 E. Madison St Date signed 7/11

VS 180

Huntington Williams, M.D.

G30664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G30664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J Henry (Strauss) Strauss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50	7	13		

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham Strauss
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Selz
15. Birthplace Germany

16 (a) Informant Mrs. Leon Strauss
(b) Address 3612 Forde Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar) JUL 12 1945

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12 1945, at 4 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10-1944 to 7-12 1945, and that I last saw him alive on 7-12 1945.

Immediate cause of death Pulmonary edema - Myocardial insufficiency. Infarction

Due to Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome R. Darkin M. D.
Address Sinai Hospital Date signed 7-12-45

93D

G30665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. G30665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs, 6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie A Crump

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Thaddeus Crump
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Nov. 27 - 1859
8. AGE: Years 85 | Months 7 | Days 14 | If less than one day ____ hr. ____ min.
9. Birthplace Virginia Richmond (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joel Taylor
13. Birthplace England

MOTHER
14. Maiden Name Eliza Mossett
15. Birthplace U S A

16 (a) Informant Walter Ret
(b) Address 3601 Erdman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Rd Balto City

18 (a) Funeral director Bernard C Frisch
(b) Address 3603 Belair Rd

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 12 1945

VS 150

Huntington Press

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944 to July 11 1945, and that I last saw h alive on July 10 1945.

Immediate cause of death	Duration
Mitral regurgitation	
Due to	
Due to	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M H Patterson M. D.
Address 2324 Reisterstown Rd Date signed 7/11/45

92B

35-8832 630666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 630666 45 D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co.
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Liberty St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. O'Conner

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-3684

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) 3-9-24

8. AGE: Years	Months	Days	If less than one day
21	3 4		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Civilian gunner
11. Industry or business

FATHER
12. Name Patrick O'Conner
13. Birthplace Md.

MOTHER
14. Maiden Name Carolyn Speis
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 1945 (month) (day) (year)
(c) Cemetery or crematory St. Francis
Location Abingdon Md.

18 (a) Funeral director Howard K. McCormick
(b) Address Abingdon Maryland

19 (a) (Date rec'd by registrar) JUL 12 1945 Registrar Huntington Williams, M.D.

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH July -9- 1945, at 11 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6- 1945, to 7-9- 1945, and that I last saw her alive on 7-9- 1945.

Immediate cause of death	Duration
Respiratory obstruction	
Due to tumor filling oral cavity	
Due to Chondrosarcoma of jaws	5 mos.
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: Chondrosarcoma of jaws

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Bennett M.D.
Address Date signed 7-11-45

X

G30667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G30667

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1150~~ 1408 Presstman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Day

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Eunice Day

6 (c) If alive, give age (years)

7. Birth date of deceased (mo., day, yr.) June 11, 1906

8. AGE: Years	Months	Days	If less than one day
39	1	-	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Richard Day

13. Birthplace Virginia

MOTHER 14. Maiden Name Maria Young

15. Birthplace Virginia

16 (a) Informant Eunice Day

(b) Address 578 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory ~~Mt Auburn~~ Lilburn Va Md

Location

18 (a) Funeral director Geo. W. Kelso

(b) Address 343 Presstman St

19 (a) 7-12-1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945 at 5 50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-10-45 at 9 45 P M.

(b) Where did injury occur? Calhoun & Presstman Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Shooting

23. Signature Roland L. Graham M.D. Medical Examiner.

Date signed July 11 1945

(over)

E. Dubal 1224 Hanover st So 0100

G30668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G30668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1420 S. Charles st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1420 S. Charles st (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby F. Kooser

3 (b) If veteran, name war

3 (c) Social Security Account No. 201-01-9512

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 22nd 1902

8. AGE: Years 42 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Pennsville Pa. (Town, county, and state)

10. Usual Occupation Sewing

11. Industry or business Davison Chemical Co.

FATHER

12. Name William Kooser

13. Birthplace Pa.

MOTHER

14. Maiden Name Sarah Howard

15. Birthplace Pa

16 (a) Informant Russell L. Kooser

(b) Address 3702 Lee st (Brooklyn)

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 12 1945 (month) (day) (year)

(c) Cemetery or crematory Smithton

Location Pennsylvania

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul st

19 (a) 111 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th 1945, at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 2/13 1945 to 7/10 1945 and that I last saw h alive on 7/10 1945.

Immediate cause of death Carcinoma of uterus with general metastases — Duration 2

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Weiler M.D.

Address 226 Hanover St Date signed 7/12/45

X

G30669

AB-69186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yr- 9mos-7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Harmony Court (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME: Barbara Bass

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lionel (D)BASS

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 4- 1898

8. AGE: Years 47 | Months 4 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: George Grabner
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Anna Hartlove
15. Birthplace: Baltimore, Md.

16 (a) Informant: Baltimore City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 12/45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL CEM.
Location ODONNELL ST.

18 (a) Funeral director Selby & Geeka Sons
(b) Address 403 S. WOLFE ST.

19 (a) 7-12-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8- 1945, at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1941 to 7-8 1945, and that I last saw her alive on 7-8 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Herbert B. Garland Jr.
Address Baltimore City Hosp. Date signed 7/9/45 M.D.

VS 150

G306.0 SZETMARA BALTIMORE CITY HEALTH DEPARTMENT G306.0

CERTIFICATE OF DEATH 1115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Eye Ear Hosp
(b) Street address 1214 Eutaw Place
(c) Hospital or institution: Baltimore Eye Ear Nt Hospital adm. 7-10-45
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 436 S. ROBERSON (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Szetmara

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Joseph Szetmara 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1881

8. AGE: Years	Months	Days	If less than one day
63yrs	8	30 24	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business AT HOME

FATHER
12. Name JOSEPH KNAP
13. Birthplace Hungary

MOTHER
14. Maiden Name Barbara Hentzig
15. Birthplace Hungary

16 (a) Informant Joseph Szetmara
(b) Address 436 S. Roberson

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 14/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director Lillian Gerlach
(b) Address 403 S. WOLFE ST.
19 (a) JUL 12 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 1945, at 3a M
21. I certify that death occurred on the date above stated; that I attended deceased from Operated on 7-10-45 to 19..., and that I last saw h.. alive on 7/11 1945.

Immediate cause of death Cardiac Failure — Duration
Due to Acute Dilitation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 7/10/45
Major findings of operation: Hyperplasia Tonsils - HYPERTROPHIED
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis Brown M. D.
Address Gibbons & Gft. Date signed 7/11/45

VS 3

G30571

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G30571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 N. Rose Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 N. Rose Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Fecher

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Fecher
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 20, 1866
8. AGE: Years 79 | Months 1 | Days 23 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Solderer
11. Industry or business Owens Illinois Co.

FATHER
12. Name Julius Fecher
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Elizabeth Fecher (wife)
(b) Address 217 N. Rose Street,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave
18 (a) Funeral director Fielder Jenkins
(b) Address 1303 W. Lafayette

JUL 12 1945 (Date rec'd by registrar) (b) Huntington Hillcrest, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July-12- 1945, at 3-30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to July 12 1945 and that I last saw him alive on July 10- 1945

	Duration
Immediate cause of death: Edema Lungs	1 day
Due to: Chronic Myocarditis	5 yrs
Due to:	
Other Conditions Arteria-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Gill Hall, M. D.
Address 1631 E. North Ave Date signed 7-12-45

X

G30672

AB 94593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G30672

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 602 S. Lakewood Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Thomas Herr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10-1875

8. AGE: Years	Months	Days	If less than one day
69	8	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired Furn Sales M'n

11. Industry or business

FATHER — 12. Name John Herr (D)

13. Birthplace Germany

MOTHER — 14. Maiden Name Bertha Gephardt (D)

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Ext'd.

18 (a) Funeral director Lilly & Zeller

(b) Address 403 South Wolfe Street

19 (a) JUL 12 1945 (Registered by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 1.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1945, to 7-11- 1945, and that I last saw him alive on 7-11 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	?
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature T. P. Jernigan M. D.

Address Baltimore City Hosp. Date signed 7-11-45

VS 150

G-10673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G-10673

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Marion Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Augustus Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1874

8. AGE: Years 70 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace N. C. Co. Ned (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Rhoda Cooper
15. Birthplace Md

16 (a) Informant Emma Brown
(b) Address 1210 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July (month) (day) '45 (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) 7 12 1945 (Date received by registrar) Huntington Wilkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9 1945; at 1:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1945, to 7/9 1945 and that I last saw her alive on 7/7 1945.

Immediate cause of death Chronic Myocarditis — Duration 3 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. H. Hanks, M.D.
Address 45 W. Biddle St. Date signed 7/10/45

VS 250

G30574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G30574

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harrison Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fullerton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Rayme

3 (b) If veteran, name war

3 (c) Social Security Account No. 264-01-8847

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura B. Rayme

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1880

8. AGE: Years 65 | Months 0 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name William Rayme
13. Birthplace Rockbridge Co. Va.

MOTHER
14. Maiden Name Margaret Snow
15. Birthplace Rockbridge Co. Va.

16 (a) Informant Mrs. R. H. Rayme
(b) Address Fullerton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Halethorpe, Md.

18 (a) Funeral director Pagenhart Funeral Home
(b) Address 3401 Belair Road

19 (d) JUL 12 1945 (Date rec'd by registrar) (b) Filed for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1945, to July 11 1945, and that I last saw him alive on July 11 1945.

Immediate cause of death	Duration
Terminal broncho-pneumonia, bilateral	
Due to Hypertensive cardio-vascular heart disease.	
Due to Generalized arteriosclerosis, dry gangrene of	
Other Conditions lower extremity, which resulted in amputation	

Date of operation July 6, 1945
Major findings of operation: Ruptured aorta
of autopsy: Terminal broncho-pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. V. Rangle
Address Md. General Hospital Date signed 7-12-45

R. V. RANGLE, M.D.

VS 150

G30675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G30675

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Overlea (Rosebury)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 E. Overlea Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jessie Steffan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/68

8. AGE: Years	Months	Days	If less than one day
76	6	12	hr. min.

9. Birthplace A.A.Co. Maryland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business at Home

FATHER
12. Name ? Brian
13. Birthplace A. A. Co. Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Max Orlove
(b) Address 3 W. Elm Ave., Overlea

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14th 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director Lasagna Funeral Home
(b) Address 7401 Belair Road

19 (a) JUL 12 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 1945 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 1945 to 7/11 1945 and that I last saw h.e.r alive on 7/11 1945

Immediate cause of death Carcinomatosis (Origin?)

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions Pathological Fracture of Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident Coat. by
(b) Date of occurrence July 2, 1945 at M
(c) Where did injury occur? 102 E. Overlea Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Injured boarding and fell while

23. Signature

Address 21 Douglas Hgts. Date signed 7/11/45 M. D.

Approved: Robert L. Fisher M.D.

G30576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Clearview (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alan Rogove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-33

8. AGE: Years	Months	Days	If less than one day
11	7	17	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Samuel Rogove
13. Birthplace Pa.

MOTHER
14. Maiden Name Helen Shearer
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 45 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh
Location Windsor Mill Rd.

18 (a) Funeral director Jos. Levin & Sons
(b) Address 1600 E. Baltimore St.

JUL 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945 at 8:33 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1945 to July 11 1945 and that I last saw him alive on July 11 1945

Immediate cause of death Brain tumor — post operative

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/10/45

Major findings of operation: Brain tumor — post operative

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul W. Chambers M.D.
Address 1600 E. Baltimore St. Baltimore, Md. Date signed 7/11/45

VS 150

G30677 — BALTIMORE CITY HEALTH DEPARTMENT — G30677

CERTIFICATE OF DEATH 170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. JOSEPH'S HOSPITAL 5 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 EAST STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Uthea Harris Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-22

8. AGE: Years	Months	Days	If less than one day
23 22	4	17	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Maryland Harris
13. Birthplace Md -

MOTHER
14. Maiden Name Emma Harris
15. Birthplace Balto, Md

16 (a) Informant Emma Marshall
(b) Address 421 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 14 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VR 44 7-12-1945

MEDICAL CERTIFICATION

KO

20. DATE OF DEATH July 9, 1945, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-9-45 at 9/9 12 30 A. M.
(b) Where did injury occur? Frederick & Eden
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Collision of Auto & Truck

23. Signature Robert Lee Bratton Medical Examiner. M.D.
Date signed July 9 1945

X

G30678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30678 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1215 E. Oliver Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

9-9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 E Oliver St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bell Hardy

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Joseph Hardy
6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 22, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	18	##### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

MOTHER / FATHER
12. Name: George Van Borden
13. Birthplace: Baltimore, Md.
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mr. Joseph Hardy (Husband)
(b) Address: 1215 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Road

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) JUL 12 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to July 10 1945, and that I last saw h[illegible] alive on July 10 1945.

Immediate cause of death: Coronary Occlusion — Duration: 1 hour
Due to: Coronary artery disease — 9 mos
Due to: Coronary Sclerosis — ?
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Thomas J. Mackie M. D.
Address: 522 E. 22nd St. Date signed 7/11/45

G30679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G30679

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 S. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 S. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. O'Hara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Married

6 (b) Name of husband or wife Lucy E. O'Hara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/20/1887

8. AGE: Years	Months	Days	If less than one day
58	3	21	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business B. & O. R.R.

FATHER
12. Name James O'Hara
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Johnson
15. Birthplace Md

16 (a) Informant Lucy E. O'Hara
(b) Address 100 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director J. H. Pumphrey & Son
(b) Address 850 W. Baltimore St

19 (a) JUL 12 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10/1945, at 7.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 10 1945 and that I last saw him alive on July 10 1945

Immediate cause of death Coronary Thrombosis — Duration 42 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. P. Johnson M. D.
Address 403 Med Arts Bg Date signed 7-11-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630680

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 49a

Registered No. G 0680

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital 11 or 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 W. Lanvale St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN Jane A. Buddecke

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George D. Buddecke.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1878

8. AGE: Years 67 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home.

FATHER
12. Name John Martin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Jane Burns
15. Birthplace Winchester, Va.

16 (a) Informant Jane D. Buddecke
(b) Address 129 W. Lanvale St. (Daughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Stewart & Monument Co
(b) Address 1020 North Ave, City

19 (a) JUL 12 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23 1945 to 7-12 1945, and that I last saw her alive on 7-11 1945

Immediate cause of death Carcinomatosis.

Due to Adenocarcinoma of Lt. ovary

Due to

Other Conditions Hypertension
Ascites.
(Include pregnancy within 3 months of death)

Date of operation 5-30-45

Major findings of operation: Peritoneal implants, biopsy - adenocarcinoma of ovary

of autopsy: Adenocarcinoma of Lt. ovary
Hypertrophy of Uterus

Duration
5 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address Church Home & Hosp. Date signed 7-12-45

Awaiting for Will

X

G30631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G10631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1 Bellona Ave & Belvedere

(c) Hospital or institution: Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo.

(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltocity

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4012 Penhurst Ave. (If rural, give location)

Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Fannie May Cherry

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Laurence J. Cherry

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April-16-1867

8. AGE: Years 78 | Months 2 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace: Phila Pa. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER 12. Name: George Metz

13. Birthplace: Penna.

MOTHER 14. Maiden Name: Deborah Lentz

15. Birthplace: Penna

16 (a) Informant: Miss Laura E. Cherry (daughter)

(b) Address: 4012 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July-13-45 (month) (day) (year)

(c) Cemetery or crematory: Greenmount

Location: Baltimore.

18 (a) Funeral director: Chas. H. Morgan & Co.

(b) Address: 1641 Mt. Ave.

19 (a) JUL 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10/45 19 , at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to 7/10 1945 and that I last saw her alive on 7/9 1945

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 7 Y.

Due to: Pernicious Anaemia

Due to:

Other Conditions: Mild Hypothyroidism - ?

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Jack. H. Morgan

Address: 1641 Mt. Ave. Date signed: 7/12/45 M.D.

VS 150

X

G30682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Uppercs
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac H Schafer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mary Shoffer

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug 22-1883

8. AGE: Years 61 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name William L Shoffer
13. Birthplace Md

MOTHER
14. Maiden Name Lydia C Hoffman
15. Birthplace Md

16 (a) Informant Preston Shoffer
(b) Address Uppercs Md

17 (a) Burial (b) Date thereof July 14/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Zion
Location Balto Co

18 (a) Funeral director Edw C Gapton
(b) Address Hampstead Md

19 JUL 12 1945 (b) Keating for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945 at 12 20 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis; Fracture of legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-9-45 at 10 P. M.
(b) Where did injury occur? Hamstead, Md Carroll Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Grayton M.D.
Medical Examiner.
Date signed July 12 1945

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

630683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131B

Registered No. 630683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3612 Hamilton Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3612 Hamilton Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mary Dressel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	M

6 (b) Name of husband or wife George E. Dressel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At home

FATHER

12. Name Gustav Beckman

13. Birthplace Osnabrueck, Germany

MOTHER

14. Maiden Name Augusta F. Crone

15. Birthplace Cincinnatti, Ohio

16 (a) Informant Mr. George E. Dressel

(b) Address 3612 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Leonard J. Funk

(b) Address 5305 Harford Road

19 (a) JUL 12 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 28 1945 to July 11 1945 and that I last saw h er alive on July 11 1945

	Duration
Immediate cause of death Myocardial insufficiency	2 months
Due to Endocarditis & Myocarditis	5 yrs.
Due to Chronic Nephritis	33 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D.

Address 5713 Bel Air Rd. Date signed 7-12-45

X

G30684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G30684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1031 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine ClarkCraver

3 (b) If veteran, name war

3 (c) Social Security Account No. 157-01-6336

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas Harvey

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Nov. 11 1890

8. AGE: Years 54 | Months 8 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Phil. Pa.
(Town, county, and state)

10. Usual Occupation Saleswoman

11. Industry or business L.A. Robinson

FATHER
12. Name Thomas H. Gahns
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Pa

16 (a) Informant Thomas H. Craver
(b) Address 1031 Hanover St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7 / 14 / 45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Trenton N. J.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Aden Sts.

19 (a) 7-9-1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to July 12 1945, and that I last saw him alive on July 12 1945. (saw him / deceased)

Immediate cause of death: Acute Cardiac Dilation.
Duration: 5 min.

Due to: Anemia
Due to: Hypertension.
Duration: several months or Years

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James Graham Manton M. D.
Address 61 Cathedral St Date signed 7-13-45

VS 180

G30685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No. G30685

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Wabash Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Wabash Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Hailer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie V. Hailer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 10, 1858

8. AGE: Years	Months	Days	If less than one day
86	10	-	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Retired Steward
11. Industry or business

FATHER
12. Name Charles Hailer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine
15. Birthplace Germany

16 (a) Informant Mrs. Nellie V. Hailer
(b) Address 3414 Wabash Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1945 (Month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Miller Lamoreaux
(b) Address 4600 Liberty Heights Ave.

19 (a) JUL 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 9.59 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to July 10 1945 and that I last saw h. in alive on July 9 1945

	Duration
Immediate cause of death Auricular fibrillation	2 min.
Due to Chronic myocarditis	2 yrs.
Due to Mitral insufficiency	2 yrs. +
Hypertension	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4600 Liberty Hgts Ave. Date signed

G30686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G30686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Newington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 2
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Newington Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SADIE G. COOK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Adolph O. Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1867.

8. AGE: Years	Months	Days	If less than one day
77	10	6	hr. min.

9. Birthplace Nashville, Tenn. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown,
13. Birthplace Unknown.

MOTHER
14. Maiden Name Esther Frey,
15. Birthplace Unknown

16 (a) Informant Mr. Jerrold Cook,
(b) Address 815 Newington Ave.

17 Removal & Int. (b) Date thereof 7/13/45. (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Nashville, Tenn.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1802 Eutaw Place.

JUL 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th. 1945 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to July 12 1945
and that I last saw her alive on July 10 1945

Immediate cause of death Carcinoma of breast — Duration

Due to Brain Concussion

Due to Ch Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Homstein M. D.
Address 733 N. Asquith St. Date signed

X

G50687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50687
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Dagsboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Steelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1894

8. AGE: Years	Months	Days	If less than one day hr.	min.
51	3	27		

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Feed Merchant

11. Industry or business

FATHER
12. Name John Steelman
13. Birthplace Del

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Leroy Steelman
(b) Address Dagsboro Del

17 (a) Red Men's (b) Date thereof July 15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Red Men's Dagsboro Del
Location Delaware

18 (a) Funeral director Welch Funeral Home
(b) Address 2008 Orleans St

19 (a) JUL 13 1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1945 to 7-12 1945 and that I last saw h. alive on 7-12 1945.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to vasomotor instability	
Due to Brain tumor	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-9-45

Major findings of operation: Large tumor in right frontal lobe.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. M. Mace M. D.
Address University Hosp. Date signed 7-12

G50688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G50688 ✓ Registered No. 1639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1536 John Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Lee Warnick

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband John Warnick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5th 1915

8. AGE: Years	Months	Days	If less than one day
29	9	7	hr. min.

9. Birthplace Staunton Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Wm F. Mullenax
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Hanger
15. Birthplace Va

16 (a) Informant John Warnick
(b) Address 1536 John St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/13/45 (month) (day) (year)
(c) Cemetery or crematory Thorn Rose
Location Staunton Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington for Willis Registrar

JUL 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 19, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH [redacted] Chloral Hydrate Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 12 1945 12 20 P M.
(b) Where did injury occur? 1536 John St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Swallowed Chloral hydrate

23. Signature Roland Lee Graham M.D. Medical Examiner.
Date signed July 12 1945

AB-93756 C20689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. C20689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos. 19days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 6

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2323 N. Charles St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: Mary Va. Steenken

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25- 1876

8. AGE: Years 69 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas R. Savin

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Jane A Aitken or Aitkn.

MOTHER 15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md.

18 (a) Funeral director William Cook Inc

(b) Address 127 S. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11- 1945, at 7.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22- 1945 to 7-11 1945, and that I last saw her alive on 7-11 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of uterus	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation /

Major findings of operation: /

of autopsy: Carcinoma of uterus; cachexia.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Thomas J O'Neill M. D.

Address Balto. City Hosps Date signed 7-11-45

VR 150 13 1945 Huntington Williams, M.D.

C-0390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C-0390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 940 Homestead St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 940 Homestead St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME G. Edward Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Loretta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y Aug 22nd 1878

8. AGE: Years	Months	Days	If less than one day
66	10	18	hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Self

FATHER 12. Name Unknown Harrison

FATHER 13. Birthplace "

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant Loretta Harrison

(b) Address 940 Homestead St.

17 (a) Burial (b) Date thereof 7/13/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) 7-13-1945 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th 1945, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1945 to July 10 1945 and that I last saw h~~im~~er alive on June 3, 1945

Immediate cause of death Arteriosclerotic Cardiovascular disease

Duration

Due to

Due to

Other Conditions Cardiac decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jack J. Singer M. D.

Address 506 E North Ave Date signed 7-10-45

C-0691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C-0691 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 N. Glover st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
Street No. 703 N. Glover st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Nelson

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or divorced. Widowed

6 (b) Name of husband or wife Peter Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2nd 1864

8. AGE: Years 81 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Lloyd Shipley
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Nelson Woolfer
(b) Address 1627 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45
(month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) JUL 13 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11th 1945, at 11 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9th 1945 to July 11th 1945 and that I last saw her alive on July 11th 1945.

Immediate cause of death	Duration
Coronary thrombosis	3 day
Due to arteriosclerosis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jankin M. D.
Address 100 N. Milton Ave Date signed 7/11/45

VS 150

C20692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C20692

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney Brice

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3765

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1892

8. AGE: Years	Months	Days	If less than one day
52 53	8	23	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Stephen Brice
13. Birthplace Va

MOTHER
14. Maiden Name Lucindia ?
15. Birthplace Va

16 (a) Informant: Goldsberry Brice
(b) Address 1107 Warner St

17 (a) Burial (b) Date thereof 7/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaac L. Bowman
(b) Address 1062 W Montgomery St

19 (a) JUL 13 1945 (b) [illegible]
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 1945, at 6.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 7-9-45

VS 151

C-0693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. C-0693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S. Jacobs Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1888

8. AGE: Years	Months	Days	If less than one day
56	9	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Balto. Ingot Co

FATHER
12. Name Charles S. Jacobs Sr
13. Birthplace Q. A. Co

MOTHER
14. Maiden Name Sallie Stevenson
15. Birthplace Md

16 (a) Informant Charles S. Jacobs Jr
(b) Address 1114 E. Lanvale St

17 (a) Burial (b) Date thereof July 16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director Jas. H. Valentine
(b) Address 2526 Eiker St.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150 JUL 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1945 at 7 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1945 to 7/12 1945, and that I last saw him alive on 7/12 1945.

Immediate cause of death	Duration
Cerebral Embolism	
Due to Bronchogenic Carcinoma of Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Bronchogenic Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 7/12/45

C50694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

C50694 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 E. 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs. (?)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk, Md. - City - 22
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Brookview Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Howard Enoch Paige Gertrude E.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. Howard E. Paige

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct. 14th. 1889

8. AGE: Years 55 56 | Months 9 | Days 27 | If less than one day 5 hr. 9 min.

9. Birthplace Maine
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name (?) McLean (d)
13. Birthplace Scotland

MOTHER
14. Maiden Name (?) Doyle
15. Birthplace ?

16 (a) Informant Mr. Howard E. Paige
(b) Address 1735 Brookview Rd. Dundalk Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-45 (month) (day) (year)

(c) Cemetery or crematory Pine Hill
Location Baltimore Md.

18 (a) Funeral director John J. Meroth
(b) Address 4201 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Huntington Woods Cemetery

VS 130 JUL 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1945 to 7/12 1945 and that I last saw her alive on 7/12 1945

Immediate cause of death	Duration
Cerebral Embolus	20 hrs.
Due to Hypertensive Cardio-Vascular Disease	6 yrs.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. W. Armstrong Jr. M. D.
Address 332 E. University Pkwy. Date signed 7/12/45

G80695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G80695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1206 Mc Cubbin Court (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Davis Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1945

8. AGE: Years | Months 6 weeks | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Albert Johnson

FATHER 13. Birthplace South Carolina

MOTHER 14. Maiden Name Keeney Johnson

MOTHER 15. Birthplace North Carolina

16 (a) Informant Albert Johnson

(b) Address 1206 McCubbin Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Eutaw Place

19 (a) JUL 13 1945 (Date rec'd by Registrar) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10 1945; at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 10 1945, and that I last saw him alive on July 10 1945

Immediate cause of death: Bilateral Pneumonia — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Rowena A. Hall, Author

Address Hopkins Hospital Date signed 7-10-45 M.D.

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C00696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. C00696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 N. Pine St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvester Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 1888

8. AGE: Years	Months	Days	If less than one day
57	4	5	hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Orderly
11. Industry or business Univ Hospt

FATHER
12. Name
13. Birthplace unknown

MOTHER
14. Maiden Name
15. Birthplace unknown

16 (a) Informant Carrie Lee Gallop
(b) Address 904 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Edmondson Ave.

19 (a) JUL 13 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 2140 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Pain death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Aortic Valvulitis

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Clements M.D.
Medical Examiner.
Date signed July 11, 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

PRINT, WITH UNFADING INK.

G60697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G60697 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5210 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5210 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles C. Kaufuss.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218.03.6123

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6 1885

8. AGE: Years 59 | Months 8 10 | Days 5. | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Clement Kaufuss

13. Birthplace Scotland

MOTHER 14. Maiden Name Catherine Shaffer

15. Birthplace Balto Md.

16 (a) Informant Mrs Gertrude E. Kaufuss

(b) Address 5210 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive

Location Randallstown Md

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave

19 (a) (Date received by Local Registrar) JUL 13 1945 (b) Huntingtown Calvert Co. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945 at 1.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to July 11 1945 and that I last saw him alive on July 10 1945

Immediate cause of death Cerebral Embolism — Duration 2 days

Due to Coronary Embolism — 30 days

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Bramble M. D.

Address 4129 Liberty Hts. Date signed July 11

X

C20698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C20698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Prince George Co Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John W Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Frances Brown
15. Birthplace Md

16 (a) Informant William Cooke
(b) Address 1805 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Sina Brannen A Hensley
(b) Address 578 N Bridle Ln

19 (a) (b) Huntington Williams M.D. Registrar

JUL 13 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1945, at 7:20 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular thrombosis
Cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 10 1945

GE0609

BALTIMORE CITY HEALTH DEPARTMENT 1133 George St
CERTIFICATE OF DEATH 83a

Registered No. GE0609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 Argyle AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edgar Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-22-0468

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15-1884

8. AGE: Years	Months	Days	If less than one day
61	2	26	hr. min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Thomas Donaldson
13. Birthplace N. C

MOTHER 14. Maiden Name Viola ?
15. Birthplace N. C

16 (a) Informant Aaron Donaldson
(b) Address 1723 E. Eager St

17 (a) Shipyard (Burial, cremation, or removal) (b) Date thereof 7 13 45 (month) (day) (year)
(c) Cemetery or crematory Raleigh N. C
Location NC

18 (a) Funeral director Raymer Sanders
(b) Address 1412 E. Preston St Huntington Williams, Mgr

19 (a) (b) Registrar

JUL 13 1945

VS 150

Approved: Hugh

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945 at 8:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 6 1945 to July 11 1945 and that I last saw him alive on July 11 1945

Immediate cause of death: Cerebral thrombosis — Duration 5 days

Due to: Cerebral hemorrhage

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1412 E. Preston St Date signed July 13 1945

Treated by me from July 6 1945 to July 11 1945 M.D.

C 0700

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

830 Registered No. C 0700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1145 Argyle Ave
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1145 Argyle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Lee Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Elizabeth Curtis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1857

8. AGE: Years 88 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Northampton Va. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Benjamin Curtis
13. Birthplace Northampton Va

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Alice Brooks
(b) Address 1145 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13 '45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Deputy Registrar) (b) JUL 13 1945 Huntington Williams Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1945 to 7-10 1945 and that I last saw him alive on 6-10 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 550 Dolphin St Date signed 7-11-45

C-0701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

C-0701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.S.A.
(b) Street address 1650 Mulligan St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1650 Mulligan St (If rural give location)
(e) Citizen of foreign country? Mulligan St (Yes or No) If yes, name country

3 (a) FULL NAME William King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mary King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Handy man
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary King
(b) Address 1650 Mulliken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1545 Pleasant Ave

19 (a) JUL 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1945, at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an ~~Inspection~~ Autopsy thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis
Degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Lubinski M.D.
Medical Examiner.
Date signed 7/14/45

X

C50702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

C50702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 W. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 W. Preston St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Huell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Jake Huell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Williamsburg S.C.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Mackey Davis
13. Birthplace S.C.

MOTHER
14. Maiden Name Susie Davis
15. Birthplace S.C.

16 (a) Informant Jake Huell
(b) Address 530 W. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory
Location Williamsburg S.C.

18 (a) Funeral director Elroy A. Wilson
(b) Address 2000 Pennsylvania Ave

19 (a) JUL 13 1945 (Date received by registrar) Huntington Williamsburg

MEDICAL CERTIFICATION

7/12/45

20. DATE OF DEATH July 12 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 12 1945 and that I last saw h[illegible] alive on July 12 1945.

Immediate cause of death	Duration
Lobar pneumonia	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M. D.
Address 515 Carlington Date signed 7/13/45

VS 150

X

GC0703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C

GC0703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5403 Burlington Way
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN Thiess MUELLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	

6 (b) Name of husband or wife George R. Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-7-97

8. AGE: Years	Months	Days	If less than one day
47	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name John C. Thiess
13. Birthplace Maryland ?

MOTHER
14. Maiden Name Laura O'Donnell
15. Birthplace Maryland ?

16 (a) Informant Husband
(b) Address 5403 Burlington Way.

17 (a) Burial (b) Date thereof July 14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (b) Huntington Williamsport Md.
(Date rec'd by registrar)

VS JUL 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 10 1945 and that I last saw h[illegible] alive on July 10 1945

Immediate cause of death Angina Syndrome, Coronary Thrombosis

Due to Hypertensive Cardio-Vascular Disease

Due to Possible Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. D. Lucas M. D.
Address Union Memorial Hospital Signed 7-11-45

X

C5C704 BALTIMORE CITY HEALTH DEPARTMENT X 96 ✓ C5C704

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural, Fort Howard (City 19)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bayside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Samuel J. Shamanski ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-0697

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs Gabriella Elizabeth Shamanski 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1900

8. AGE: Years	Months	Days	If less than one day
44	11	27	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Joseph Shamanski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Andrulevicz
15. Birthplace Poland

16 (a) Informant Gabriella E. Shamanski
(b) Address Bayside Ave - Fort Howard Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)

(c) Cemetery or crematory Saint Stanislaus Balto. MARYLAND.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JUL 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945, to July 12 1945, and that I last saw him alive on July 12 1945.

Immediate cause of death	Duration
Cerebral embolism	
Due to Post operatively following operation for ligation of aneurysm	
Due to of Circle of Willis	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation July 10, 1945

Major findings of operation: Aneurysm of Int. Carotid at Circle of Willis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Casey M. D.
Address U. M. H. Date signed 7-12-45

X

C00705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 C

Registered No. C00705

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 S. Light St.

(c) Hospital or institution: So. Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County — So 1416

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1718 Alexander St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Vaugh Leroy Gardiner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-45

8. AGE: Years	Months	Days	If less than one day
0	1		hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James W. Gardiner

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Lucy Shipperry

15. Birthplace W. Va.

16 (a) Informant James W. Gardiner

(b) Address 1829 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick ave.

18 (a) Funeral director John F. Lyons, Inc.

(b) Address 715 Light St.

19 (a) JUL 13 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945, at 9:19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1945 to 7-10 1945 and that I last saw him alive on 7-10 1945.

Immediate cause of death acute nutritional disturbance - diarrhea of the new born

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. Ehrlich M. D.

Address 1213 Light St. Date signed 7-10-45

VS 150

X

C30706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C30706

Registered No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address Middle or Howard
(c) Hospital or institution: Maryland General 37
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5625 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Christopher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Clara Bella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 - 1884

8. AGE: Years	Months	Days	If less than one day
60	8	14	hr. min.

9. Birthplace Dorchester Co, Md
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business

FATHER
12. Name Francis H.
13. Birthplace Dorchester Co, Md.

MOTHER
14. Maiden Name Willie Banning
15. Birthplace Dorchester Co Md

16 (a) Informant Mrs. Nellie Walter
(b) Address 5625 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem
Location Taylor ave

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway

19 (a) JUL 13 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12/45 19 , at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions Hypertensive Cardio Vascular Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John C. Davis, M.D.
Medical Examiner
Date signed 7/12/45

G00707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G00707

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baptist Home 1615 Park, Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie C. Cox

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/1857

8. AGE: Years	Months	Days	If less than one day
88	5	3	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss. Halderman
(b) Address 1615 Park, Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) JUL 13 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945 at M

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1945 to July 12, 1945, and that I last saw h[illegible] alive on July [illegible]

Immediate cause of death

	Duration
Due to Chr Myocarditis	several years
Due to Hypertension	
Other Conditions old age	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Hurst C. Blake M. D.
Address Med. Arts Date signed

G:0708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

G:0708 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 division st
(c) Hospital or institution: Provident Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 28hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 750 W. Fairmount ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Simmons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-45

8. AGE: Years	Months	Days	If less than one day
4		1	4 hr. min.

9. Birthplace Baltimore, md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Simmons
13. Birthplace Jamestown, S.C.

MOTHER
14. Maiden Name Inez Brown
15. Birthplace Jamestown, S.C.

16 (a) Informant Inez Simmons
(b) Address 750 W. Fairmount ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 APR 13 1945 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1945 to 7/9 1945.
and that I last saw him alive on 7/9 1945.

Immediate cause of death Hemorrhage

Due to Hemorrhage
Disease of Nfer Born

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maybelle L. Weare M. D.
Address 1944 Druid Hill Ave Date signed 7/11/45

VS 150 Kept for anatomical Purposes

GC0709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 5 8 E

Registered No. GC0709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 297 Mason Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ferracci

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1939

8. AGE: Years 6 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Ferracci
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jeanette Di Nenna
15. Birthplace Balto., Md.

16 (a) Informant Jeanette Ferracci
(b) Address 297 Mason Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Walbrook Ave.

18 (a) Funeral director Frank Reilly & Son
(b) Address 52 N. Morley St

19 (a) JUL 13 1945 (rec'd by Registrar) (Registrar) Huntington Ave. & Belair Rd, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945, at 3:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 12 1945, and that I last saw her alive on July 12 1945.

Immediate cause of death	Duration
Cardiac respiratory failure.	
Due to Acute rheumatic fever. Acidosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick
Address Mercy Hosp. Date signed 7/12/45 M.D.

VS 150

C80710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

C80710 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 228 Mt. Olivet Lane

(a) Baltimore City, Maryland

(b) Street address 228 Mt Olivet Lane

(c) Hospital or institution: 20-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 228 Mt. Olivet Lane. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Milton Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-4923

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances A. Davis.

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	14 1/2	hr. min.

9. Birthplace Wilmington Delaware. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Retired

FATHER 12. Name Samuel Davis.

13. Birthplace Delaware.

MOTHER 14. Maiden Name Eunice Johnson

15. Birthplace Unknown

16 (a) Informant Frances A. Davis, wife.

(b) Address 228 mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director Dill Bros.

(b) Address 3109 Frederick Ave.

19 (a) (Date filed by registrar) JUL 16 1945 (b) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13th 1945 at 315 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 9 1945, and that I last saw h[illegible] alive on July 9 1945.

	Duration
Immediate cause of death Myocardial	3 weeks
Due to Arteriosclerosis	many years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed 7/13/45 M. D.

C0711 Zuschlag ✓ C0711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Clinton St.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Clinton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Zuschlag.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife George.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 17 - 1877
8. AGE: Years 67 | Months 11 | Days 1 | If less than one day hr. min.
9. Birthplace Washington D C (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frederick Rutter
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Geo. Zuschlag
(b) Address 1617 Clinton St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-41 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Holy Redeemer
Location Balto Md
18 (a) Funeral director Funeral Chapel
(b) Address 5205 Harford Rd
19 (a) JUL 13 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4- 1940 to 7-13 1945 and that I last saw h ed alive on 7-12 - 1945.

Immediate cause of death	Duration
Hypertension	1940
arteriosclerosis	1940
Due to Chr. nephritis	1940
Coronary thrombosis	
Due to arteriosclerosis	1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Mulholland M. D.
Address 2230 Eutaw Pl. Date signed 7-13/45

C0712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

C0712 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 B
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Damico

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-8-97

8. AGE: Years	Months	Days	If less than one day
48	4	1	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Pipe Helper
11. Industry or business

FATHER
12. Name James Damico
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Augusta
15. Birthplace Italy

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Randell & Lizzul
(b) Address 312 S. Highland Ave

19 (a) JUL 13 1945 (Date rec'd by registrar) (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945 at 3:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 45 to July 9 1945 and that I last saw him alive on July 9 1945.

Immediate cause of death: High Intestinal Fistula — Duration: 1 week
Due to: Disruption anterior Gastrojejunostomy — 1 week
Due to: Duodenal Ulcer — 1 year
Other Conditions: Pneumonia

(Include pregnancy within 3 months of death)
Date of operation 6/21/45
Major findings of operation: Duodenal Ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos Hampton M.D.
Address Johns Hopkins Hosp. Date signed 7/9/45

C50713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160c

Registered No. C50713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS REQUIRED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 N Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Baltimore Fallston
(If outside city or town limits, write RURAL and give town)
(d) Street No. Union Mem. Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Tincher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1945

8. AGE: Years	Months	Days	If less than one day
		1	36 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ~~Sydney Lloyd~~ Ray Lee Tincher
13. Birthplace ~~West Virginia~~ Maryland

MOTHER
14. Maiden Name Alberta Clark
15. Birthplace West Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Body disposed of by hospital
Location

18 (a) Funeral director
(b) Address

19 JUL 13 1945 (Date rec'd by registrar) (b) Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 1 1945, and that I last saw ~~him~~ her alive on July 1 1945

Immediate cause of death	Duration
Unknown	
Due to Acute Poison Ivy Dermatitis & secondary infection (mother)	
Due to	
Other Conditions Prematurity; Partial Premature Separation of Placenta	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchizedek Spragues M.D.
Address 6 M M Date signed 7-5-45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No. C50714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Sollers Point Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: James Hill
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Kathryn Geddis
15. Birthplace: Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 10 1945

18 (a) Funeral director: Commissioner of Health
(b) Address

19 (a) JUL 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 6:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945, to July 4 1945, and that I last saw him alive on July 4 1945

Immediate cause of death: asphyxia neonatorium — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Gilbert J. Vosburgh M. D.

Address Johns Hopkins Hospital Date signed 7-5-45

E-325

C30715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157B

Registered No. C30715

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT FOLD OR BEND

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Balto md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 723 Radnor Ave

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Caroline Sue Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/24/45

8. AGE: Years | Months | Days 16 | If less than one day — hr. — min.

9. Birthplace Balto Balto, md.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name William Gibson Cooper

13. Birthplace Middleport, Ohio

MOTHER

14. Maiden Name Clara Laura Smith

15. Birthplace Coolville Ohio.

16 (a) Informant William Gibson Cooper

(b) Address 723 Radnor Ave

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory .....

Location Body disposed of by hospital

18 (a) Funeral director .....

(b) Address .....

19 JUL 13 1945 Huntington-Williams, Md

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1945 19 ..., at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1945 to 7/10 1945 and that I last saw h[illegible] alive on 7/10 1945.

Immediate cause of death	Duration
Spina Bifida	
Due to	
Due to	
Other Conditions Bilateral pes Valgus	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Wm N. Hodges M. D.

Address Union Mem. Hosp. Balto. md Date signed 7/13/45

VS 150

G50716 Nee G50716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully handled. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Sulgrave Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27.15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Sulgrave Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Ince

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Ince

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1869

8. AGE: Years 75 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Chorley England (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Thomas E. Ince
(b) Address 1621 Sulgrave Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-45 (month) (day) (year)
(c) Cemetery or crematory Loretto Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Young Byers
(b) Address 5085 Park Heights Ave

19 (a) JUL 13 1945 (Date received by Registrar) Huntington Hall, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 12 1945 and that I last saw h alive on

Immediate cause of death: Coronary Thrombosis — Duration 3 days

Due to Arteriosclerosis

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman R. Hunt
Address 2601 Manhattan Ave Date signed 7/13/45

X

G20717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1923

G20717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Fendall Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Harrington (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nehemiah Draper

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Gleason Draper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1863

8. AGE: Years 82 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name Avery Draper
13. Birthplace Delaware

MOTHER
14. Maiden Name Sarah Tinley
15. Birthplace Delaware

16 (a) Informant Mrs. Arthur E. Magill
(b) Address 3025 Fendall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Harrington Methodist Church Cem.
Location Harrington, Del.

18 (a) Funeral director Willis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

JUL 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945, at 1.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to July 12 1945 and that I last saw him alive on July 11 1945

Immediate cause of death: Cerebral Embolism — Duration 14 days
Due to: Hypertension — 6 mos.
Due to: Senile Infirmity — 6 mos.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Liberty Hgts Ave. Date signed

C0718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

C0718 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully enrolled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 East 32nd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 28

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4916 Roland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Mr. ~~Martin~~ L. Aler (Martin L. Aler)

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 718-07-5346

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1895

8. AGE: Years 49 | Months 8 | Days 28 | If less than one day 11 hr. 10 min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Mr. Frank B. Aler

13. Birthplace West Virginia

MOTHER 14. Maiden Name Mildred Thompson

15. Birthplace West Virginia

16 (a) Informant Mrs. Sally Mary Moses Sister

(b) Address 4403 Atwick Road Moses

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location Pikesville, Md.

18 (a) Funeral director Miller Lamotte

(b) Address 4520 Liberty Heights Ave.

19 (a) JUL 13 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1945 at 11:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1945 to 7/12 1945 and that I last saw h. alive on 7/12 1945

Immediate cause of death: Aortic Aneurysm — Duration: 2 yrs.

Due to

Due to

Other Conditions: Alcoholism.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Aortic Aneurysm

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Snyder, III

Address Union Memorial Hospital Date signed 7/12/45 (M. D.)

VS 150

X

C50719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C50719

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4013 Liberty Heights

(c) Hospital or institution: Nursing Home 12.5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Mo.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 20 East Lanvale St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Merceret

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
About 85	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Louis Merceret

13. Birthplace France

MOTHER 14. Maiden Name Rebecca Baltzell

15. Birthplace Maryland

16 (a) Informant Natalie M. Merceret

(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md.

18 (a) Funeral director Wm. U. Mears and Son

(b) Address 805 N. Calvert St.

19 JUL 13 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13th 1940, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to July 13th 1942, and that I last saw h.e.r. alive on July 8th 1945.

Immediate cause of death Uremia,

Due to Interna Salpingitis.

Due to Nephritis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Huntington Williams M.D.

Address 3000 St Paul St. Date signed July 13/45.

VS 15C

C30720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

C30720

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 S. Payson st
(c) Hospital or institution: 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Payson st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Ann Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband: John L. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 23rd 1866

8. AGE: Years: 79 | Months: 4 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Self

FATHER
12. Name: (Unknown) Hannon
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant: Edward B. Martin Jr.
(b) Address: 4955 Edgemere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul st.

19 (a) JUL 14 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13th 1945, at 12 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to July 13 1945, and that I last saw her alive on July 13 1945.

	Duration
Immediate cause of death: Central Hemorrhage	1 day
Due to: Hypertension	?
Due to: Generalized Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Bokheimer M. D.
Address 1 W. Fulton Ave Date signed 7-13-45

VS 150

G20721 290537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G20721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS ASSISTED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Bartlett Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bradfield
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-75

8. AGE: Years 69 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation R. R. retired
11. Industry or business

FATHER
12. Name James Bradfield
13. Birthplace Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Md.

16 (a) Informant Friends -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Wilson Funeral Home
(b) Address 1317 Eutaw St.

19 (a) JUL 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1945 at 12-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1945 to July 12 1945 and that I last saw him alive on July 12 1945

Immediate cause of death: Intestinal obstruction
Due to Malignancy (?) Malignancy
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 7-9-45
Major findings of operation: markedly destroyed large bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Mueller Jr. M.D.
Address The Johns Hopkins Hosp. Date signed 7-12-45

VS 150

G30722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30722 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem Shipyards Key Highway
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21-1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 Russell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Krebs

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-5419

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/2/1889

8. AGE: Years	Months	Days	If less than one day
56	5	10	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Boiler maker

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown Krebs
13. Birthplace Wash., D.C.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Viola Krebs (wife)
(b) Address 1026 Russell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 JUL 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1945, at 2 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gaston M.D. Medical Examiner.
Date signed July 13 1945

X

TUCK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 F

Registered No. G50723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED: M-27642
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W West St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy Tuck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race wgo | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 11, 1945 (June 24, 1945)

8. AGE: Years 0 | Months 0 | Days 8 | If less than one day — hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Berkley Tuck

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Odessa Cureton

MOTHER 15. Birthplace York, S. Carolina

16 (a) Informant mother

(b) Address —

17 (a) CITY DISPOSAL (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory —

Location UNIVERSITY MEDICAL SCHOOL JUL 13 1945

18 (a) Funeral director Commissioner of Health

(b) Address —

19 JUL 14 1945 (Date rec'd by registrar) (By) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1945, at 3:40 o'clock P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/4 1945 and that I last saw h[illegible] alive on 7/3 1945

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Prematurity

Due to Cong. Syphilis

Other Conditions Toxemia of Pregnancy 8 months

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Leonard T Kurland M. D.

Address University Hospital Date signed 7/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MUST BE RECEIVED FOR BINDING

VS 150

2828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C60924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Emergency Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214½ Penna. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Bruce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/24/45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? unknown
13. Birthplace

MOTHER
14. Maiden Name Emma Bruce
15. Birthplace Va.

16 (a) Informant Emma Bruce
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) JUL 14 1945 (Signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1 1945, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1945 to 7-1 1945, and that I last saw h[illegible] alive on 7-1 1945.

Immediate cause of death Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mabel E. Drake M. D.
Address Univ. Hospital Date signed 7-2-45

VS 150

F 2827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13 1a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Entries must be typewritten or written in ink FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) 15-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 E. Madison St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Camper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widow

6 (b) Name of husband or wife Monroe (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1886

8. AGE: Years	Months	Days	If less than one day
59	2	28	hr. min.

9. Birthplace Aureyo, Md (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sylvester Montimore
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Pinder
15. Birthplace Md

16 (a) Informant Henrietta Stanley
(b) Address 1517 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/45 (month) (day) (year)
(c) Cemetery or crematory
Location Aureyo, Md

18 (a) Funeral director Joseph B. Lockwood
(b) Address 1326 N. Central Ave

19 (a) Date received JUL 14 1945 (b) Registrar's signature Huntington Mills, Registrar MJ

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 1945, at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/11 1945
and that I last saw h[illegible] alive on 7/11 1945

Immediate cause of death	Duration
Cerebral hemorrhage	10 days.
Due to hypertensive cardio-	
Due to renal disease	unk.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jayne Browne. X
Address 1520 E. Madison St Date signed 7/12

C50726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V159

C50726
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1237 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elaine Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Buchanan
13. Birthplace Va

MOTHER
14. Maiden Name Ethel Chase
15. Birthplace Balto. Md

16 (a) Informant Ethel Chase
(b) Address 1237 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md.

18 (a) Funeral director Joseph B. Lyles, Jr.
(b) Address 3042 N. Central Ave

19 (a) JUL 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1945, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Sex death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed July 13 1945

VS 151

CHARGO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Reg. 930727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 2 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 N. Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY [redacted] CHARGO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 29, 1874

8. AGE: Years 70 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Conyers

13. Birthplace Unknown

MOTHER 14. Maiden Name Adelaide Butler

15. Birthplace St. Mary's Co. Md.

16 (a) Informant Ella Williams

(b) Address 1025 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Wm. Cam. H. Wheeler

(b) Address 1631 Druid Hill Ave. Huntington Williams, Md.

19 (a) (Date rec'd by Registrar) JUL 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/45 19 at 3:40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxia

Due to Obstruction of bowels

Other Conditions Intestinal Obstruction from Cancer

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner

Date signed 7/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C30728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C30728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LINDEN AVE. AND MADISON STS.
(c) Hospital or institution:
MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 5 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY FARMER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 8, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	5	— hr. — min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name WILLIAM FARMER
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name LILLIAN Miller
15. Birthplace Md.

16 (a) Informant Mrs. Lillian Miller
(b) Address 920 Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Violetville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) JUL 14 1945 (b) Registrar Huntington Williams, Md.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 13, 1945 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 8, 1945, to JULY 13, 1945, and that I last saw HIM alive on JULY 13, 1945.

Immediate cause of death PREMATURITY — Duration 5 DAYS
Due to Bronchopneumonia — 1 day
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address 104 Medical Arts Bldg. Date signed 7/13/45

X

C30729

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V131a

C30729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fenda
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aurelia Stautz AURELIA SITUTZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank J. Stautz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 26, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Henry Roth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Veronica Loetzinger
15. Birthplace Baltimore

16 (a) Informant Mrs Adele Holden
(b) Address 2932 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Henrig Sons
(b) Address 2024 Orleans St

19 (a) (Date received by Registrar) (b) Registrar

JUL 14 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1945 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1945, to 7/12 1945; and that I last saw her alive on 7/12 1945

Immediate cause of death	Duration
Asystemia	
Pulmonary Edema	
Due to Coronal Thrombosis	—
with Chronic Hypertension	
Due to Nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 7/13/45

X

G30730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Bennett Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex C

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1894

8. AGE: Years 50 Months 8 Days 15 If less than one day hr. min.

9. Birthplace A. A. County, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Geo. Brooks
13. Birthplace Anne Arundel Co

MOTHER
14. Maiden Name Mary
15. Birthplace Anne Arundel Co

16 (a) Informant Gertrude Brooks
(b) Address 905 Bennett Place

17 (a) Burial (b) Date thereof July 14, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Fulton Ave

19 (a) JUL 14 1945 Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10 1945 at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to b.d. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Stomach

Due to

Other Conditions Pulmonary Tbc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gabriele M.D.
Medical Examiner.
Date signed 7/11/45

VS 151

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C30731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58D

C30731
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution: 1514 Division st, Balto md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Allegany
(c) City or town Cumberland, (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Frederick st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Parker - (Louis)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/24/1929

8. AGE: Years	Months	Days	If less than one day
16	3	20	hr. min.

9. Birthplace Anne Arundel Co Md. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name J. W. Parker
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Carrie Markle
15. Birthplace A. A. Co., Md.

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Lothian Cem.
Location Lothian, Md

18 (a) Funeral director Mrs. Charles L. Hicks
(b) Address Annapolis, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS Jul 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 12:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945, to 7-14 1945, and that I last saw him alive on 7-14 1945.

	Duration
Immediate cause of death Heart Failure	2 Days
Due to Rheumatic Heart disease	2 months
Due to Rheumatic Fever.	4 months.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address Provident Hosp Date signed 7/14/45

C30732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

Registered No. C30732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 McCulloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 McCulloh St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Taylor

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1882

8. AGE: Years	Months	Days	If less than one day
62	8	26	hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Griffin Lewis
13. Birthplace Va.

MOTHER
14. Maiden Name Maria ?
15. Birthplace Va.

16 (a) Informant Gazelle Taylor Ward (Daug)
(b) Address 1625 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/45 (month) (day) (year)
(c) Cemetery or crematory Sharon Baptist Cem.
Location Lancaster Co. Va.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) [illegible] (Registrar) Huntington Williams M.D.
Date JUL 14 1945

VS 180

MEDICAL CERTIFICATION

A

20. DATE OF DEATH 7/13/45 19 , at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 19 to 7/13 19 45 and that I last saw him alive on 7/13 19 45

Immediate cause of death	Duration
(a) Pthisis	Chronic
Due to (b) Pulmonary	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7/15

G30733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30733 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d.
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2641 Loyola Northway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Goldman
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Richard Goldman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 5, 1898
8. AGE: Years 34 Months 8 Days 9 If less than one day hr. min.
9. Birthplace South America (Town, county, and state)
10. Usual Occupation Hswf.
11. Industry or business

FATHER
12. Name Eli Cornblatt
13. Birthplace South America

MOTHER
14. Maiden Name Clara Baer
15. Birthplace South America

16 (a) Informant Richard Goldman
(b) Address 2641 Loyola Northway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-45 (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location
18 (a) Funeral director Jacob Lewis Inc
(b) Address 439 E. Balto. St
19 (a) 7.14.1945 (Date rec'd by Registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 1945, at 5:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1945, to 7/14 1945 and that I last saw her alive on 7/14 1945.
Immediate cause of death Respiratory Obstruction — Duration
Due to Carcinoma of Larynx
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Alan C. Tilley Jr.
Address Mercy Hosp. Date signed 7/14/45

VS 180

G30734 Kole G30734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Nova Hotel. 1900 N. Charles St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2/12 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1900 N. Charles St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Hyman Kole.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-9515

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Chicago, Ill. (town, county, and state)

10. Usual Occupation Tailor Woman

11. Industry or business

FATHER 12. Name —

13. Birthplace Russia

MOTHER 14. Maiden Name —

15. Birthplace Russia

16 (a) Informant Albert Kaye

(b) Address 2000 E. Biddle St

17 (a) [redacted] (Burial, cremation, removal) (b) Date thereof 7-14-45 (month) (day) (year)

(c) Cemetery or crematory Chicago Ill

Location

18 (a) Funeral director Jack Levine Inc

(b) Address 1339 E. Baltimore St

19 (a) JUL 14 1945 (b) Huntington Williams, Mgr

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 13 1945 and that I last saw h[illegible] alive on July 13 1945

Immediate cause of death Cerebral hemorrhage

Due to Hypertension

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. N. MacMurchy M. D.

Address 801 Bunker St Date signed 7/15

VS 180

Approved: Robert Lee Fretter M.D.

G30735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G30735 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3918 Maine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 Maine Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Silverman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Susie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1878

8. AGE: Years	Months	Days	If less than one day
66 67	11	28	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Bernard Silverman
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Mrs Hattie Rudolph
(b) Address 3918 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUL 15 1945 (Date rec'd by registrar) (b) Huntington Mills

VS 150

MEDICAL CERTIFICATION 2.30

20. DATE OF DEATH July 14 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to July 13 1945 and that I last saw h[illegible] alive on July 13 1945.

Immediate cause of death Acute coronary insufficiency — Duration

Due to Ch arteriosclerosis

Due to Parkinson's disease

Other Conditions Ch myocarditis

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Hamaker M. D.
Address 733 Argonne Dr Date signed 7/14/45

X

G30736 ✓ G30736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause and age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 902 Druid Hill Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 902 Druid Hill Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Green Muse

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-8596

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Charlie Muse

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) June 17, 1918

8. AGE: Years 27 | Months — | Days 26 | If less than one day ... hr. ... min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Gordon Box Co.

FATHER 12. Name Luke Green

FATHER 13. Birthplace South Carolina

MOTHER 14. Maiden Name Emma Johnson

MOTHER 15. Birthplace South Carolina

16 (a) Informant Emma Green

(b) Address 902 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1945

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

19 (a) JUL 15 1945 (Date received by reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1945, at 9 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1945 to 7/13 1945, and that I last saw h alive on 7/10 1945.

Immediate cause of death acute Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 7/14/45

VS 160

X

G30737

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30737 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Walnut St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Effria Fooks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leona
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Salisbury Parks
Location Salisbury Md
18 (a) Funeral director Fulton & Johnson
(b) Address 483 Dock St
19 (a) JUL 17 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945 at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14, 1945 to July 15, 1945 and that I last saw him alive on July 15, 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	
Other Conditions CNS lues	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Ott, Jr.
Address Union Hosp. Balto. Date signed 7/15/45 M. D.

VS 180

C30738 C30738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 Kensington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Kensington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy M. Gullatt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth nee Holloway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1904

8. AGE: Years	Months	Days	If less than one day
40	7	2	hr. min.

9. Birthplace Alabama
(Town, county, and state)
10. Usual Occupation Dry Cleaner
11. Industry or business Own Business

FATHER
12. Name Frank Gullatt
13. Birthplace Alabama

MOTHER
14. Maiden Name Nora Lee —
15. Birthplace Alabama

16 (a) Informant Mrs Elizabeth Gullatt
(b) Address 419 Kensington Road

17 (a) Removal (b) Date thereof 7-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Memphis Tenn

18 (a) Funeral director Harry H Whitlike
(b) Address 4101 Edmondson Ave.

19 (a) 1945 Filed by registrar Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1945, at 8 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fatty degeneration of Liver; Early cirrhosis of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 14, 1945

For Appeal

C60709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C60709

2941 Westerstown Road 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3032 Virginia Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3032 Virginia Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Gajic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Bessie Gajic

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1905

8. AGE: Years	Months	Days	If less than one day
40	3	22 25	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name	Vincent Gajic
FATHER — 13. Birthplace	Bohemia
MOTHER — 14. Maiden Name	Evangelina Konzak
MOTHER — 15. Birthplace	Bohemia

16 (a) Informant Bessie Gajic

(b) Address 3032 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-45 (month) (day) (year)

(c) Cemetery or crematory Oak Hill

Location Baltimore Md

18 (a) Funeral director Heath Broadway

(b) Address 700 N. Eutaw St

19 (a) 7-15-1945 (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945, at 2:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22/45 19 to 7/13/45 19, and that I last saw h[illegible] alive on 7/13/45 19

Immediate cause of death Ac. Pulmonary Edema

Due to Ac. Coronary Thrombosis

Due to Coronary Sclerosis & Insufficiency

Other Conditions Angina Pectoris

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nicholas Appelfeld

Address 2511 Kenilworth Dr Date signed 7/14/45

VS 150

(over)

G30740

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1576

G30740

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County
(c) City or town Detroit (If outside city or town limits, write RURAL and give town)
(d) Street No. 15854 Fairmount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Emmendorfer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-40

8. AGE: Years	Months	Days	If less than one day
4	10	21	hr. min.

9. Birthplace Mich. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Morton Emmendorfer
13. Birthplace Mich

MOTHER
14. Maiden Name Agnes Amman
15. Birthplace Mich.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory ?
Location Detroit, Mich.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 E. Jefferson Ave. Detroit, Mich.

(a) JUL 15 1945 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945 at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 45 to July 14 1945 and that I last saw him alive on July 14 1945.

Immediate cause of death Coronary Thrombosis

Duration

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 7/14/45

Major findings of operation Atheroma pulmonary valve

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. D. Bennett M. D.
Address The Johns Hopkins Hosp. Date signed 7/14/45

X

G80741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G80741
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Tudor Arms Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Tudor Arms Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mary Caroline Buck

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 2, 1855

8. AGE: Years: 90 Months: 4 Days: 12 If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: John Marion Buck
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Mary Frazin
15. Birthplace: Baltimore

16 (a) Informant:
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Greenmount Ave. & Oliver St.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1906 Eutaw Place

19 (a) [illegible] (b) [illegible] Registrar

JUL 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1924 to death 19; and that I last saw h[illegible] alive on 7/12/45

Immediate cause of death: Cerebral Hemorrhage

Duration:

Due to:

Due to:

Other Conditions: Arterio sclerosis, coronary arteriosclerosis, hypertension
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Chas. W. Townsend M. D.

Address: 9 E. Chase St. Date signed: 7/15/45

X

C30742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

C30742
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co
(c) City or town Fallston.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fallston, Harford Co. Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard K. Mitchell (Howard Kemp Mitchell)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida Whitson

6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1851

8. AGE: Years 94 | Months 5 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore County.
(City, county, and state)

10. Usual Occupation Retired

11. Industry or business Postmaster, Fallston, Md

FATHER
12. Name Isaac Mitchell
13. Birthplace Harford County

MOTHER
14. Maiden Name Bodensik
15. Birthplace

16 (a) Informant H. Kemp Mitchell (Son)
(b) Address Fallston, Harford Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)

(c) Cemetery or crematory Friendship
Location Fallston, Harford Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Huntington Williams (b) Registrar
(By registrar)

JUL 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1945 to 7-14 1945.
and that I last saw h/M alive on 7-14 1945.

Immediate cause of death: Shock

Due to: Fractured hip.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-13-45 at 11 A.M.
(c) Where did injury occur? Fallston (City or town) Harford (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury: Fell down steps.

23. Signature Eugene J. Kelly M. D.
Address 1420 N. Caroline St Date signed 7-14-45

Approved Robert E. Preston M.D. 7/15/45

35-6293 G80743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

Registered No. G80743

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Woodland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Leberman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	W.

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day hr.	min.
49				

9. Birthplace PHARMACIST (Town, county, and state) Poland.
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Leberman
13. Birthplace Poland

MOTHER
14. Maiden Name Lena Singer
15. Birthplace Poland

16 (a) Informant records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-45 (month) (day) (year)
(c) Cemetery or crematory Pet Chapel
Location Work Blvd.
18 (a) Funeral director Jack Davis Jr.
(b) Address 1439 E. Baltimore St.

19 1945 (b) Registered by registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9- 1945 to 7-14 1945, and that I last saw him alive on 7-14- 1946.

Immediate cause of death Toxic hepatitis

Due to Cirrhosis of the liver (Portal,

Due to

Other Conditions Chronic alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham G. Vance
Address Johns Hopkins Hosp. Signed 7/14

VS 150

C30714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

C30714
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Kirk Ave.
(c) Hospital or institution:
U.S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Kirk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorsey Callis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3 1906

8. AGE: Years	Months	Days	If less than one day
38	7	11	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Passenger

11. Industry or business Standard Oil Co. of Va.

FATHER
12. Name Luther T Callis
13. Birthplace Va

MOTHER
14. Maiden Name Janice Callis
15. Birthplace Matthews Co. Va

16 (a) Informant Marie Morgan
(b) Address 2200 Kirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month, day, year)
(c) Cemetery or crematory Mathews Chapel
Location Mathews Co. Va.

18 (a) Funeral director Ellenworth Armistead
(b) Address 3911 Liberty Heights, Ave

19 (a) 7-15-1945 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Toxemia due to
1st degree burns (1st & 2nd degree burns)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 14 1945 11 34 A.M.
(b) Where did injury occur? Canton
(c) Did injury occur at home, on farm, industrial place, in public place? S.S. Philadelphia While at work? Y
(d) Means of injury Steam pipe burst

23. Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed July 15 1945

3374 G0745 BALTIMORE CITY HEALTH DEPARTMENT G0745
CERTIFICATE OF DEATH 107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Broadway
(c) Hospital or institution Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky (b) County
(c) City or town Winchester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Van Meter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Willis Van Meter
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 3-5-00

8. AGE: Years 45 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Ky (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name R. P. Taylor
13. Birthplace Ky

MOTHER 14. Maiden Name Carolyn Pruitt
15. Birthplace Ky

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-45 (month) (day) (year)
(c) Cemetery or crematory Winchester Ky.
Location

18 (a) Funeral director John A. Morton
(b) Address 464 Greenmount Ave. Huntington Williams, Mgr

19 (a) (Date received by registrar) Registrar

JUL 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 15 - 19 45 at 1 46 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13- 19 45 to 7-15- 19 45 and that I last saw her alive on 7-15- 19 45

Immediate cause of death: Cardiac Failure — Duration: ? 3 wks
Due to: Bronchial Asthma — 20 yrs
Due to: + Lobular Pneumonia — ? 2 days
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson M.D.
Address Johns Hopkins Hosp. Date signed 7/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G30746 355366

BALTIMORE CITY HEALTH DEPARTMENT X 540

CERTIFICATE OF DEATH

Registered No. G30746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Red Lion
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Neff.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Sallie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-87

8. AGE: Years	Months	Days	If less than one day
58	2	29	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Levi Neff.
13. Birthplace Penn.

MOTHER
14. Maiden Name Susanna Shaffer
15. Birthplace Penn.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7 15 45 (month) (day) (year)

(c) Cemetery or crematory
Location Red Lion Penna.

18 (a) Funeral director Mgr Tschudy & Son
(b) Address North & Penna Ave

19 (a) Date received JUL 16 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945 at 3 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to July 15 1945 and that I last saw him alive on July 15 1945

Immediate cause of death	Duration
Embolism - pulmonary.	
Post operative pneumonia.	
Due to Cholelithiasis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/26/45

Major findings of operation Stones (multiple) - gallbladder

of autopsy: W.H.O. Surgical Case

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asa W. Saunders M.D.
Address Johns Hopkins Hosp Date signed 7/16/45
Red Lion, Pa.

VS 150

C30747 ZIMNOWODA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C30747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 15 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Zimnawoda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/14/45

8. AGE: Years	Months	Days	If less than one day
			15 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name John Zimnawoda
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie Stanton
15. Birthplace Balto. Md.

16 (a) Informant John Zimnawoda
(b) Address 621 S Patterson Pk Ave

17 (a) Burial (b) Date thereof July 16 45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Fred W Orazewski
(b) Address 1930 Eastern Ave

19 (a) JUL 16 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15/45 19 , at 1 22 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/45 to 7/15 1945, and that I last saw him alive on 7/14 1945.

	Duration
Immediate cause of death Asphyxia	
Due to Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Stratton M.D.
Address Mercy Hosp. Date signed 7/15/45

VS 150

G30748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B Registered No. G30748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Howard Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 N Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lily Bryant Sunstrom
3 (b) If veteran, name war N
3 (c) Social Security Account No. None
4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Alvin E Sunstrom
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 2, 1873
8. AGE: Years 71 | Months 9 | Days 12 | If less than one day hr. min.
9. Birthplace Kansas City Mo (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Bryant
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Alvin E Sunstrom
(b) Address 1836 N Caroline St
17 (a) Final (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location
18 (a) Funeral director Wilhoyte Cook Inc
(b) Address 2117 E Fayette St
JUL 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/1945 at 4:50 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/13/1945 to 7/14/1945 and that I last saw h CB alive on 7/14/1945

	Duration
Immediate cause of death Congestive heart failure	
Due to ? Rheumatic fever	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Grace E Crane M. D.
Address Medical Arts Bldg Date signed 7-14-45

VS 150

G30749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. G30749

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Pickwick Rd (If rural give location)
(e) Citizen of foreign country? (~~Yes~~ or No) If yes, name country

3 (a) FULL NAME LENORE PIPER COCKEY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 578-07-9228

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ John Graff Cockey

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) June 8, 1904

8. AGE: Years 40 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace Clearfield, Pa. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Scott Piper
13. Birthplace Clearfield, Pa

MOTHER
14. Maiden Name Lyon Teeter
15. Birthplace Penn.

16 (a) Informant John Graff Cockey
(b) Address 2427 Pickwick Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Jul. 16. 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

JUL 16 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 14 1945, and that I last saw her alive on July 14 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 hrs.
Due to: Aneurysma int. Carotid Artery	8 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. T. Jordan M. D.
Address Date signed 7-14-45

G30750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1172

Registered No. G30750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. N. Broadway (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HARRY ESER, SR.

3 (b) If veteran, name war No

3 (c) Social Security Account No. 212-01-7993

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Aline Eser
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) July 3, 1893

8. AGE: Years	Months	Days	If less than one day
52	0	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Vice. Pres. & Gen. Manager
11. Industry or business Continental Milling Co.

FATHER
12. Name Charles N. Eser
13. Birthplace Trenton N.J.

MOTHER
14. Maiden Name Caroline Hagedorn
15. Birthplace Baltimore Md.

16 (a) Informant G. Harry Eser, Jr. -son
(b) Address 3871 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 16 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to 7-13 1945 and that I last saw him alive on 7-13 1945

Immediate cause of death	Duration
Acute pancreatitis & chemical peritonitis	16 hrs.
Due to Ruptured Peptic ulcer	23 yrs.
Due to	
Other Conditions Jejunal or Jejunostomy	6 mos.

(Include pregnancy within 3 months of death)

Date of operation 7-12-45
Major findings of operation: Large perforated ulcer involving pancreas & lesser curv. of stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Sullivan M.D.
Address 1 East Hamilton Pl. Date signed 7-13-45

VS 150

G30751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G30751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrie Mitchell

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-10-5791

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Mitchell
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1877

8. AGE: Years 67 | Months 9 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace: Redwood, Va. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Fletcher Mitchell
13. Birthplace: Redwood, Va.

MOTHER
14. Maiden Name: Lydia Brooks
15. Birthplace: Redwood Va.

16 (a) Informant: Mrs. Margaret Mitchell-widow
(b) Address: 524 S. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) JUL 16 1945 (Date rec'd by registrar) (b) Thurston for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1945, at 9:15 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic hypertrophic degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Richard Allen Preston M.D. Medical Examiner.
Date signed July 14 1945

VS 151

G30752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G30752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 So. Ann Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 South Ann Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Barszcz (Or) Baszcz

3 (b) If veteran, name war

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~XXXX~~ John
6 (c) If alive, give age Decd years

7. Birth date of deceased (mo., day, yr.) July 26-1869

8. AGE: Years	Months	Days	If less than one day
75 76	11	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Wegrzynski
13. Birthplace Poland

MOTHER
14. Maiden Name Magdalena ?
15. Birthplace Poland

16 (a) Informant Mrs. Mary Dabrowski
(b) Address 222 South Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) JUL 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 14 1945.
and that I last saw decd alive on July 14 1945

Immediate cause of death Bronchopneumonia — Duration 10 days
Due to Pneumonia
Due to
Other Conditions Chr. Arteriosclerosis ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold J. Feeney M. D.
Address [illegible] Date signed 7/16/45

G30753

G30753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 S. Regester Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31. (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 S. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-2938

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Theodore
6 (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) January 1, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	14	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown ? Cichy
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edward Meyer (Son)
(b) Address 724 S. Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-45 (month) (day) (year)
(c) Cemetery or crematory ST STANISLAUS
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (Date received by registrar) JUL 16 1945 (Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 15 1945, and that I last saw h[illegible] alive on July 14 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage (Subarachnoid)	1 wk
Due to Cerebral Arteriosclerosis	?
Due to	
Other Conditions Chr Myocarditis Fibrocarditis (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Emma Douglas M. D.
Address 709 E. Pratt St. Date signed 7/16/45

83a

G30754 Colley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83 a

G30754 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4543 Pimlico Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 45-43 Pimlico Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John R. Colley

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.): April 19 1863

8. AGE: Years	Months	Days	If less than one day
82	2	25	hr. min.

9. Birthplace: Balto. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER 12. Name: Robert A. Colley
FATHER 13. Birthplace: Balto.

MOTHER 14. Maiden Name: Margaret Rush
MOTHER 15. Birthplace: Ireland

16 (a) Informant: Margaret Colley
(b) Address: 4543 Pimlico Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 16 45 (month) (day) (year)
(c) Cemetery or crematory: Mount Olivet
Location: Randallstown Md

18 (a) Funeral director: Martin F. Dunn Sons
Address: 1110 Baltimore Blvd

19 (a) JUL 16 1945 (Date rec'd by registrar) Huntington Williams Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 14 1945. and that I last saw him alive on July 13 1945

Immediate cause of death	Duration
(a) Arterio Sclerosis	unknown
Paralysis	
Due to Cerebral Hemorrhage	1 week
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Emer M. D.
Address 7201 York Rd Date signed 7-14-45

VS 150

G30755 6-75

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30755

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VA. (b) County
(c) City or town Martinsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Starling Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry P. Davis.

3 (b) If veteran, name war: WW

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Jessie Davis 6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 11-24-81

8. AGE: Years	Months	Days	If less than one day
63	7	21	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Steam Engineer
11. Industry or business

FATHER
12. Name H.P. Davis
13. Birthplace Va

MOTHER
14. Maiden Name Emma Davis
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Wood Mem
Location Martinsville Va
18 (a) Funeral director Martin Wm. Appl Coal
(b) Address 87 Main St.
19 JUL 16 1945 (Date rec'd by registrar) (Signature of registrar) for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7- 1945 to 7-15- 1945 and that I last saw him alive on 7-15- 1945

Immediate cause of death	Duration
Increased Intracranial Pressure	
Due to Meningitis	
Due to Carcinoma of Sinus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/14/45
Major findings of operation: Increased Intracranial Pressure
of autopsy: None Required

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Loring W. Pratt M.D.
Address Johns Hopkins Hospital Date signed 7/15/45

VS 150

G30756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G30756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important. BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3360 Hickory Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3358 Hickory Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Alice Hughlett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Robert Hughlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17-1883

8. AGE: Years 61 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or Business

FATHER 12. Name Joseph Kelly
13. Birthplace Maryland

MOTHER 14. Maiden Name Susan Isennock
15. Birthplace Maryland

16 (a) Informant Miss Millie Kelly
(b) Address 3358 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17-1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (Date received by registrar) JUL 16 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13- 1945 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 11 1944 to July 13 1945 and that I last saw her alive on July 13 1945.

Immediate cause of death: Pt. Cerebral Hemorrhage — Duration 1 day

Due to Cardio Renal Vascular Hepatosa — Duration 11 mos

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J N Wilson, M.D.
Address 617 W. 40th St Date signed 7/14/45

VS 150

G30757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133B

Registered No. G30757

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~5523 Rockleigh Drive~~
(c) Hospital or institution: St Agnes Hospital Wilkens & Caton Aves.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5523 Rockleigh Drive.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances E. Smithies.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife Mr. James R. Smithies
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1913.

8. AGE: Years	Months	Days	If less than one day
31	7	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business At Home.

FATHER
12. Name — Woodrow.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Md.

16 (a) Informant James R. Smithies.
(b) Address 5523 Rockleigh Drive.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof July 17/45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.
JUL 16 1945 (Date rec'd by registrar) (b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/1945, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/17 1945 to 7/15 1945 and that I last saw h[illegible] alive on 7/15 1945

Immediate cause of death Uremia Coma

Due to Malignant Hypertension and.

Due to Renal Insufficiency

Other Conditions ruptured ectopic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Cotter Jr. M.D.
Address St. Agnes Hosp. Date signed 7/16/45

VS 180

G30758 PRICE G30758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 N. Shroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Shroeder St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henrietta Annette Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife William S. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15 1874

8. AGE: Years	Months	Days	If less than one day
70 71	6	26	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gunnard Davis
13. Birthplace Unknown

MOTHER
14. Maiden Name Eliza Henson
15. Birthplace Md.

16 (a) Informant William S. Price
(b) Address 617 N. Shroeder St (Husband)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Q. A. to Mod

18 (a) Funeral director Isaiah A. Pearson
(b) Address 1018 W. Montgomery St

19 JUL 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1945, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 13 1945, and that I last saw h[illegible] alive on July 3 1945.

Immediate cause of death: Cardio-vascular Renal disease — Duration: 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Louise Lowry M. D.
Address 1100 Druid Hill Ave Date signed 7/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G30759

JO #94478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

Registered No. G30759

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 158 W. Henrietta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise Wyeoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Isaach or Isaah (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1878

8. AGE: Years	Months	Days	If less than one day
67	-6-	-0-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Bevans (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Louise Roselle (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1010 W. Montgomery St.

JUL 16 1945 (Date received by registrar) (b) Herrington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945, at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 8, 1945, to July 11, 1945, and that I last saw her alive on July 11, 1945.

Immediate cause of death	Duration
Malnutrition & Cachexia	?
Due to Duodenal obstruction	?
Due to Perforation of gall bladder & adhesions	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/28/45
Major findings of operation: Duodenal obstruction
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Perry M.D
Address Balto City Hosp Date signed 7/13/45 M. D.

C30760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. C30760

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1222 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Cotter Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-07-9962

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1903

8. AGE: Years: 41 | Months: 8 | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business —

FATHER
12. Name John F Cotter, Sr
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Bertha S. Hart
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Catherine E. Cotter
(b) Address 1222 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 17 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 3801 Frederick Road

18 (a) Funeral director John F. Conway & Son
(b) Address 9003 Pulaski St

19 (a) JUL 16 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1945; at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1936, to July 13, 1945, and that I last saw alive on July 1945

Immediate cause of death: Acute Heart Failure — Duration: —

Due to: Chronic Myocarditis — Duration: 9 yrs

Due to: Valvular Heart Disease — Duration: 9 yrs

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature John F Conway M. D.
Address 1222 Washington Blvd Date signed 7/17/45

C30761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C30761 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address North Calvert St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 134 N. Exeter St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Constantina Leon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Leon

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Spiros Skaves

FATHER 13. Birthplace Greece

MOTHER 14. Maiden Name Porta Panagiota

MOTHER 15. Birthplace Greece

16 (a) Informant George Leon

(b) Address 134 N. Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1945 (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox Evergreens

Location Baltimore, Md.

18 (a) Funeral director Francis Reed

(b) Address Westminster, Md.

19 (a) (Date received by Registrar) JUL 16 1945 (b) Registrar Hampton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1945 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/12 1945, and that I last saw h[illegible] alive on 7/12 1945.

	Duration
Immediate cause of death Pneumonia, terminal and heart failure	
Due to Mucous aspirations and generalized debilitation	
Due to Bed rest from intra-capsular fracture, right femur	
Other Conditions Chronic passive congestion	

(Include pregnancy within 3 months of death)

Date of operation 3/13/45

Major findings of operation Intracapsular fracture, right femur

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Jan 7 1945 at M

(c) Where did injury occur? Balto., Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)

(e) Means of injury Fall on ice

23. Signature Joseph E. Riehl M.D.

Address Mercy Hospital Date signed 7/12/45

Approved: Robert Lee Graham MD

G30762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G30762

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR FINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2535 Francis

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2535 Francis

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Edith Frances Roth.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife William H. Roth

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1889

8. AGE: Years	Months	Days	If less than one day
57	10	13	hr. min.

9. Birthplace Baltimore md.

(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business At Home

FATHER — 12. Name James A. Bateman.

15. Birthplace Baltimore md.

MOTHER — 14. Maiden Name Sallie Jackson

15. Birthplace Eastern Shore md.

16 (a) Informant William H Roth

(b) Address 2535 Francis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)

(c) Cemetery or crematory Balto., Natl.

Location Baltimore, Md.

18 (a) Funeral director Wm J Tichnor & Sons

(b) Address Balto., Md.

JUL 16 1945

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 7:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 15 1945, and that I last saw he alive on July 15 1945

Immediate cause of death Cerebral Hemorrhage — Duration 7/15/45

Due to Chr. Myocarditis — 1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Paul A Brown M. D.

Address 1663 W. Mount St. Date signed 7/16/45

VS 150

G30763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No. G30763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukeland & Raynor
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5505 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL DOWNS GERWIG

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob F. Gerwig, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1896

8. AGE: Years	Months	Days	If less than one day
48	11	19	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wayson Downs
13. Birthplace Unknown

MOTHER
14. Maiden Name Grace Olar
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Jacob F. Gerwig, Sr.
(b) Address 5505 Reisterstown, Rd.

17 (a) Burial (b) Date thereof 7/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 16 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to July 15 1945 and that I last saw h e r alive on July 15 1945

Immediate cause of death Cardiac failure — Duration

Acute Bacterial Endocarditis

Due to Rheumatic Cardio valvular disease

Due to Pulmonary Infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Hepatic replete

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roe H. Baldwin M. D.
Address West Baltimore General Hosp. Date signed 7-15-45

G30764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G30764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2511 Elsinore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Elsinore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE V. CUNKLE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1854

8. AGE: Years	Months	Days	If less than one day hr.	min.
90	10	4		

9. Birthplace Winchester, Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name - Cunkle
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name Martha Reather
15. Birthplace Winchester, Va.

16 (a) Informant Mrs. Bertha Fonshill
(b) Address 2511 Elsinore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 16 1945 (Date received by local registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1942 to July 13 1945 and that I last saw her alive on July 13 1945

Immediate cause of death Arteriosclerosis — Duration 15 yrs.
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwight Lewis M.D.
Address 1601 N. Broadway Date signed 7/14/45

VS 150

G30765
JL - 94732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G30765

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Royston Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Amick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Walter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph C. Webber
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Wilson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Milhorn Funeral Home
(b) Address 1211 Eutaw Pl.

JUL 16 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945, at 6:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1945, to July 15 1945, and that I last saw her alive on July 15 1945.

Immediate cause of death: Coronary thrombosis ? — Duration: ?
Due to: Arteriosclerosis — ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan
Address Baltimore City Hosp. Date signed 7-15-45 M. D.

To be approved by Medical Examiner.

G30766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2662 Wilkins Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town, write RURAL and give town)
(d) Street No. 2662 Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If so, name country

3 (a) FULL NAME Joseph T. Shepperd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ella E. Shepperd
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) March 16th 1870

8. AGE: Years	Months	Days	If less than one day
75	3	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Shepperd
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Bugles
15. Birthplace Md

16 (a) Informant Ella E. Shepperd
(b) Address 2662 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Minnerath Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) JUL 16 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12/1945, at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/12 1945; and that I last saw h alive on 7/12/1945.

Immediate cause of death Arteriosclerotic cardiac vascular disease

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Willis M. D.
Address 2030 Wilkens Ave Date signed 7/16/45

G30767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G30767 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 E. Madison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country U.S.A.

3 (a) FULL NAME Wilhelmina Winefred Boyce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Donald Boyce

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) November 4 1899

8. AGE: Years 45 Months 7 Days 5 If less than one day hr. min.

9. Birthplace B. N. S. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Griffith
13. Birthplace B. N. S.

MOTHER
14. Maiden Name Mary E.
15. Birthplace B. N. S.

16 (a) Informant Donald Boyce
(b) Address 1419 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Peter L. Gruss
(b) Address 1622 E. Carlton St.

19 JUL 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45 at 3:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1945 to 7/14 1945 and that I last saw h[illegible] alive on 7/13 19 45

Immediate cause of death
pulmonary tuberculosis — Duration UNK.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1519 E. Madison St Date signed 7/14
Rayner Browne

C30768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5/B

Registered No. C30768

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution: City
(d) Length of stay in hospital or inst. (yrs., mos., or days) short
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 West Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Linicar Linicar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lalsa Linicar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1893

8. AGE: Years 52 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Bath, N. C.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Abram Linicar
13. Birthplace Bath N. C.

MOTHER
14. Maiden Name Martha Linicar
15. Birthplace

16 (a) Informant Cain Bryant
(b) Address 1127 N. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16 45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 7 6 1945 (Date rec'd by registrar) (b) [illegible] 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/45 19 at 8:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 7/12/45

VS 151

G30769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

R G30769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 N. Calhoun
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N. Calhoun
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Charles Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26. 1882

8. AGE: Years 63 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Va (town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Felland Brown

13. Birthplace Va

MOTHER 14. Maiden Name Harriet Morris

15. Birthplace

16 (a) Informant Julius Johnson

(b) Address 808 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)

(c) Cemetery or crematory Dennis

Location Mt. Summerland Balto 20

18 (a) Funeral director Sam'l. N. Chase & Son

(b) Address 638 N. Gilmor St.

17 JUL 16 1945 Registrar

Registered JUL 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16-1945 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-1944 to 7-16 1945, and that I last saw h alive on 7-15 1945.

Immediate cause of death Chronic Cardio Vascular Disease Hypertension — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Lawrence M.D.

Address 6004 Ludlow Date signed 7/16/45

X

VA JUL 16 1945

G30770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G30770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3713 Monarch Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Monarch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Palmeri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-45

8. AGE: Years	Months	Days	If less than one day
			hr. 1.05 min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Guy Palmeri
13. Birthplace Md

MOTHER 14. Maiden Name Catherine Boykenzo
15. Birthplace Md

16 (a) Informant Guy Palmeri
(b) Address 3713 Monarch Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-16-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Leonard Bloch
(b) Address 505 Hartford Road

19 (a) JUL 16 1945 Hunting for Williams, Mgr
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death Asphyxia

Due to Accidental drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Drowning

23. Signature Francis L. Bagley Jr. M.D.
Date signed 7/16/45

Bamford & Christopher

VS 150

G30771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ G30771 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hos.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 S. Tolna St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Va.

3 (a) FULL NAME Margaret Van Essen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	

6 (b) Name of husband Gerrit Jay Van Essen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16-1907

8. AGE: Years	Months	Days	If less than one day
38	5	29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Mc Mahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Kelly
15. Birthplace Ireland

16 (a) Informant Gerrit Jay Van Essen
(b) Address 629 S Tolna St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 / 18 / 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Frank Pelle Sons
(b) Address 52 N. Morley St

19 JUL 16 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945 at 8:A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1945 to July 15 1945 and that I last saw her alive on July 15 1945

Immediate cause of death Pulmonary Edema

Due to Myocardial Insufficiency

Due to Vitamin deficiency?

Other Conditions Rental Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L Rosenthal M. D.
Address Sinai Hospital Date signed 7-15-45

93E

G30772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G30772

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Eden
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robert Allen Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18th 1905

8. AGE: Years 40 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Cumberland Co Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Jefferson
13. Birthplace Va

MOTHER 14. Maiden Name Susie Allen
15. Birthplace Va

16 (a) Informant Jessie R Kemp
(b) Address 803 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location O. O. Co. Md

18 (a) Funeral director Bafron Virginia H. Knight
(b) Address 727 Pinquad St

19 (a) Filed JUL 16 1945 Registrar

Huntington Hall

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12 1945 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1945 to 7/12 1945 and that I last saw him alive on 7-12 1945.

Immediate cause of death: (a) Lobar Pneumonia Duration: 4 days
Due to: (b) Asthma 5 days
Due to: (c)
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Lake M. D.
Address 227 N. Eutaw Date signed 7/13

X

G30773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1577

Registered No. G30773

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Dundalk Bathing Beach Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bell Biggers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-37

8. AGE: Years	Months	Days	If less than one day
7	10	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Arthur Biggers
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Moses
15. Birthplace Del

16 (a) Informant Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Jos. S. Locke Jr
(b) Address 801 Central ave

JUL 16 1945 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 '45 to July 15 1945 and that I last saw h.. alive on July 15 19 45

Immediate cause of death: Cachexia — Duration: Months

Due to Spastic Quadriplegia — Months

Due to Congenital Malformation of Brain — Life

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter M. Jarem

Address [illegible] Date signed 7/15/45 M. D.

VS 150

G30774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 120a

G30774 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
Street No. 1820 W Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Kay Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/43

8. AGE: Years	Months	Days	If less than one day
2	16+	16	hr. min.

9. Birthplace Grafton W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Donald Anderson
13. Birthplace Rowlesburg W. Va.

MOTHER
14. Maiden Name Virginia Hamdon
15. Birthplace Tunnelton W. Va.

16 (a) Informant John Anderson
(b) Address 1820 W Fayette

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)

(c) Cemetery or crematory Tunnelton
Location Taylor Co. W. Va.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Filed by registrar 7/16 1945 (b) Registrar Washington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945 at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1945 to 7/16 1945 and that I last saw her alive on 7/16 1945

Immediate cause of death dehydration
acidosis

Due to diarrhea & vomiting

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P Downes M. D.
Address University Hosp. Date signed 7/16

G30775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1363

G30775
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 N. Ellwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. ELIZABETH KELLEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William S. Kelley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1915

8. AGE: Years: 30 | Months: 2 | Days: 13 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Clement Floyd
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rose Montgomery
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Rose Floyd (Mother)
(b) Address 3469 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. JUL 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1941, to July 1945, and that I last saw her alive on July 14 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. W. Jacobson M. D.
Address 230 Eutaw Place Date signed 7-16-45

VS 159

X

G30776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G30776 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Riddick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10.26.1930

8. AGE: Years 14 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Pittsburgh Pa
(Town, county, and state)

10. Usual Occupation school

11. Industry or business

FATHER
12. Name Louis Riddick
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Lucy Eubanks
15. Birthplace Virg

16 (a) Informant Lucy Riddick
(b) Address 1605 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/45 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, PA.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentberry ave.

19 (a) 1945 (b) Registrar
(Do not write above this line)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1945, at 12.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9.18 1945 to 7.14 1945 and that I last saw her alive on 7.13 1945

Immediate cause of death: pulmonary tuberculosis — Duration 4 or. months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne

Address 1500 E. Madison St Date signed 7.14 1945

M.D.

Rayner Browne X

G30777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30777 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 Wildwood Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Monastery ave,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace B. Lewis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Herbert F. Lewis Sr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1876

8. AGE: Years	Months	Days	If less than one day
69	0	5	hr. min.

9. Birthplace Elizabeth, N.J.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John Passaman
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Herbert Lewis
(b) Address 503 Wildwood Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Young-Boyer
(b) Address 5065 Park Heights Ave

19 (a) (Date received by registrar) (b) Arrington Williams, M.D. Registrar

JUL 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945 to July 14 1945 and that I last saw h. alive on July 13 1945.

Immediate cause of death

		Duration
(1)	General Paralysis	5 to 7 yrs
Due to	Cerebral Hemorrhage	1941
(2)	Diabetes	10 yrs
Due to		
(3)	Hypertension	10 yrs
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. B. Enos M. D.
Address 4936 Park Hgts Ave Date signed 7-16-45

X

G30778 ✓ G30778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Sherman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John A. Sherman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 8, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Thomas S. Cox
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary Mooney
15. Birthplace Ireland
16 (a) Informant Miss E. Cox
(b) Address 1503 Register St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore
18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave
19 (a) Huntington Williams (Signature of registrar)

JUL 16 1945

VS 150

Dr. LeCompte 1 North Gay X

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to July 17 1945; and that I last saw alive on July 15 1945.

Immediate cause of death	Duration
Cardiac Insufficiency	?
Due to	
Sen. Arteriosclerosis	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel LeCompte M.D.
Address 1716 E. Monument Date signed July 17 1945

G30779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G30779 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2066 Linden Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Mae Libby

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	F	W	

6 (b) Name of husband or wife Wm. Walsh Libby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-1876

8. AGE: Years	Months	Days	If less than one day
66	8 9	29	hr. min.

9. Birthplace Reisterstown, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John E. Crout
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah F. Brown
15. Birthplace Md.

16 (a) Informant Mrs. Elsie Stephens
(b) Address 2036 Park Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre Cem.
Location Phila., Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1945 to 19 .
and that I last saw h.er alive on 7-16 1945

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to vasomotor instability	
Due to Operation for brain tumor	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-10-45
Major findings of operation: Adioma of brain.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Mayer M. D.
Address Univ. Hosp. Date signed 7-16-45

X

G30780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30780 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 N. Jackson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Berberich

3 (b) If veteran, name war

3 (c) Social Security Account No. 226-05-0298

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ann Berberich
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) October 18, 1905

8. AGE: Years	Months	Days	If less than one day
39	8	27	hr. min.

9. Birthplace Petersburg, Va. (Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business

FATHER
12. Name Adolph V. Berberich
13. Birthplace Germany

MOTHER
14. Maiden Name Fannie Morek
15. Birthplace Kansas

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road Baltimore Md.

17. (a) Date of death (month) (day) (year) July 16 1945
(b) Burial, cremation, or removal? Burial
(c) Cemetery or crematory Mt. Park Cem.
Location Fairfax Va.

18 (a) Funeral director Sherwood Monroe.
(b) Address 1080 W. Baltimore St.

19 (a) Date rec'd by reg. JUL 17 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 6 a.m. p. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 16 1945, and that I last saw him alive on June 16 1945.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Diabetes Mellitus	1½ mos.
Due to	
Other Conditions Manic-depressive psychosis (Superadded)	1½ mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D'Alaya M. D.
Address 336 Judefield Rd. Date signed

(OVER)

G30781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94B

Registered No. G30781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 - days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Reese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Wh.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 65

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name " "
15. Birthplace "

16 (a) Informant Hayden Bollinger
(b) Address Route 6 - Westminster

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Near Westminster

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 JUL 17 1945 (Date rec'd by Registrar) (b) Huntington Billings M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 12 1945 to Jul 16 1945, and that I last saw living alive on Jul 16 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Toxemia, pneumonia	
Vincents angina, lung abscess	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address University Hosp. Date signed 7-16-45

VS 150

G30782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160

G30782 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook & Catonsville.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (~~year, month~~ or days) 1
(e) Length of stay in Baltimore (~~year, month~~ or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city, give town or township, and write RURAL after name)
(d) Street No. St Agnes Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Diggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/15/45

8. AGE: Years	Months	Days	If less than one day
			24 hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wilmer H. Diggs
13. Birthplace Staunton Va

MOTHER
14. Maiden Name Betty Mae Robinson
15. Birthplace Va.

16 (a) Informant Wilmer H. Diggs (Father)
(b) Address 3911 - 8th St. Brooklyn

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Thorn Rose
Location Staunton Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 1:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1945 to 7/16 1945 and that I last saw h alive on 7/16 1945

Immediate cause of death	Duration
Prematurity	
Due to Placenta Praevia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/15/45

Major findings of operation: Placenta Praevia

Section of autopsy: Placenta Praevia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. B. McFaddin M. D.
Address St Agnes Hospital Date signed 7/16/45

VS 180

G30783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 a

Registered No. G30783

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 93 Cl. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Pitcairn (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Mary Belle Little

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1945 [illegible] 1879

8. AGE: Years	Months	Days	If less than one day
65	10	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Wallace
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name ?
15. Birthplace Pennsylvania

16 (a) Informant Mr. Little
(b) Address Pitcairn, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery or crematory Braddock Cem.
Location East Liberty, Pa.

18 (a) Funeral director Mary M. Funkfelt
(b) Address 50[illegible] East 22nd Street

19 Jul 17 1945 (Date rec'd by registrar) Huntington Williams Mgr. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1945 to July 16 1945, and that I last saw h[illegible] alive on July 16 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Generalized Arteriosclerosis	
Due to Straining at stool	
Other Conditions Fracture left hip. due to fall from ladder, July 5, 1945. (Include pregnancy within 3 months of death)	

Date of operation: Case Applied July 7 45
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 5, 1945 M
(c) Where did injury occur? Pittsburgh, Pa (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? no
(e) Means of injury Fall from ladder

23. Signature Paul S. Crate M. D.
Address U.M.H. Date signed 6-16-45

VS 150

For Med. Exam. Approval C. L. Schmidt M.D.

G30784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30784

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Women's Hospital
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Bolton Street, Balto. Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Katherine Foley

3 (b) If veteran, name war: 10

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/1875

8. AGE: Years	Months	Days	If less than one day
69	7	0	hr. min.

9. Birthplace Baltimore City Maryland (Town, county, and state)

10. Usual Occupation housekeeper

11. Industry or business Mrs Van Bibber

FATHER
12. Name Thomas D. Foley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Whalen
15. Birthplace Ireland

16 (a) Informant Mrs. Phillip McGregory
(b) Address 345 Yale Ave. Irvington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery ~~cremation~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 JUL 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1945, to July 16th 1945, and that I last saw her alive on July 15th 1945.

Immediate cause of death: Pulmonary edema and hydrothorax - bilat. — Duration 48 hrs

Due to: Hypertension - intracranial cardiovascular disease. — 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: pulm. edema - hydrothorax

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Abbatiello M. D.
Address 3606 E. Cold St. Date signed July 16 45

C30785
JL - 94705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. C30785

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Isaac Garrison

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Sara (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	28	hr. min.

9. Birthplace Md.
(Town, county, or state)
10. Usual Occupation Unemployed Porter
11. Industry or business Linotype

FATHER
12. Name George Garrison
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Collins
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn (Balto)
Location

18 (a) Funeral director Samuel H. Chase Funeral Home
(b) Address 638 N. Gilmor St.

19 JUL 17 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS, 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 14 1945, and that I last saw him alive on July 14 1945.

Immediate cause of death Respiratory failure — Duration

Due to Cardiac failure

Due to Arteriosclerotic heart disease

Other Conditions Prostatic urethral obstruction - hydronephrosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary edema Congestion Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathon Howland M. D.
Address BEH Date signed 7/16/45

G30786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

15-9

Registered No. G30786

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: President Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 1 week

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1642 W. Gilmore

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Alfred Culley Bosewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-45

8. AGE: Years	Months	Days	If less than one day
0	0	8	hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Alfred Culley Bosewell

13. Birthplace

MOTHER

14. Maiden Name Mary Wilfie Jones

15. Birthplace Stat of Georgia

16 (a) Informant neighbor

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 16 1945

18 (a) Funeral director: Commissioner of Health

(b) Address

19 (Date rec'd by registrar) JUL 17 1945 Huntington Williams M.D.

VS 150

2840

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1945, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 - 1945, to 6-29 1945, and that I last saw him alive on 6-25 1945.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. R. Campbell M. D.

Address 718 Dolphin Date signed 7-15-45

G30787 D'ANTONI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

Registered No. G30787

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: West Balto Gen't Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town # 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 238 N Payson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent D'Antoni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Rae (cupe)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/31/1882

8. AGE: Years	Months	Days	If less than one day
63	1 May	31	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Fruit Dealer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace Italy

16 (a) Informant Joseph J. D'Antoni (son)
(b) Address 238 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Greenmount Ave

19 (a) JUL 17 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 6'15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to July 15 1945, and that I last saw him alive on July 14 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Toxic Nephritis	
Other Conditions Hepatitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Adam M. D.
Address West Balt. Gen. Hosp Date signed 7/14/45

VS 180

G30788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30788

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town, give RURAL route or town)

(d) Street No. 1419 W Lombard St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Clarence E. Moffett

3 (b) If veteran, name war

(c) Social Security Account No. 213-10-0160

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nora Moffett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1878

8. AGE: Years	Months	Days	If less than one day
67	2	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Shop supt.

11. Industry or business Balto. Transit Co.

FATHER

12. Name Samuel Moffett

13. Birthplace Maryland

MOTHER

14. Maiden Name Amanda McPherson

15. Birthplace Maryland

16 (a) Informant Mary Moffett

(b) Address 1419 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-45 (month) (day) (year)

(c) Cemetery or crematory Wesley Chapel

Location Rock Hall Md

18 (a) Funeral director Geo. E. Beyer Jr

(b) Address 1512 Hollins St.

JUL 17 1945 (Date received by Registrar) (b) Huntingdon Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to July 15 1945, and that I last saw him alive on July 12 1945.

	Duration
Immediate cause of death Cardiac failure	
Due to Pneumonia	1 week
Due to	
Other Conditions Hypertension C.V. disease	4

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Vincent A. P. Forstenzer M.D.

Address Mercy Hospital Date signed July 15 '45

VS 150

X

G30789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G30789

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 725 N. Appleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton A. Emery Sr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 218-05-9644

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Viola W. Emery.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7-1887

8. AGE: Years	Months	Days	If less than one day
58	6	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Pipefitter
11. Industry or business

FATHER
12. Name Geo. W. Emery.
13. Birthplace Md

MOTHER
14. Maiden Name Florence Mallonee
15. Birthplace Md

16 (a) Informant Mrs. Viola W. Emery.
(b) Address 725 N. Appleton

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** July 19-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore Md

18 (a) Funeral director Geo. R. Berger Jr
(b) Address 512 Holliday St

19 JUL 17 1945 (Date rec'd by Registrar) **(b)** Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 12:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1945 to July 14 1945, and that I last saw h living alive on July 13 1945.

Immediate cause of death	Duration
Due to Cirrhosis of Liver	4 mos ca.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature M Bowman Lord, M. D.
Address 2200 Jefferson Blvd. Date signed 7/14/45

G30790 FUNK ✓ 61 G30790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Town~~ Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Funk

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Isabella F
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1881

8. AGE: Years	Months	Days	If less than one day
63 64	0 10	18	hr. min.

9. Birthplace Balto (Town, county, and State)
10. Usual Occupation Retired Laundry
11. Industry or business

FATHER 12. Name Henry
13. Birthplace Germany

MOTHER 14. Maiden Name Amelia Geaper
15. Birthplace Germany

16 (a) Informant Mrs Herbert Wells
(b) Address 2009 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 17 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Edward Fowlkes
(b) Address 2359 West Pratt Blvd

JUL 17 1945 (a) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 16 1945 and that I last saw him alive on July 16 1945

Immediate cause of death	Duration
a Circulatory Collapse	6 months
Due to Cerebral accident ?	
Due to Hypertension	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Robinson M. D.
Address University Hospital Date signed 7-16-45

VS 150

83a

C30791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C30791

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1913 Eutaw Place

(c) Hospital or institution Twilight Rest & Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1529 W. Balto St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Friedman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Louis

13. Birthplace Russia

MOTHER 14. Maiden Name Deborah

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-45 (month) (day) (year)

(c) Cemetery or Crematory Loudale Jewish Cem

Location Park Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) JUL 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-45 19 , at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 45 to 7-17- 19 45 and that I last saw him alive on 7-16- 1945

Immediate cause of death Carcinoma Rectum — Duration ?

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas B. Shreeve M. D.

Address 54 S. Fulton Ave. Date signed 7-17-45

VS 150

C30792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Register No. C30792

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5528 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5528 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Helen Clowney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John F. Clowney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9th 1878

8. AGE: Years	Months	Days	If less than one day
66	9	5	hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Hoey
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Biddison
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Helen Gates
(b) Address 3318 Lawnview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 17 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 Filed JUL 17 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1945, at 7-35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to July 14 1945 and that I last saw him alive on July 13 1945

Immediate cause of death Metastatic Carcinoma — Duration 2 years
Due to Carcinoma Uterus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation April 1936
Major findings of operation: Carcinoma Uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 4810 Belair Rd Date signed July 16/45

VS 150

G30793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G30793

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 S. DEAN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S. DEAN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA SAAL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	WIDOWED

6 (b) Name of husband or wife CONRAD SAAL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 30, 1872.

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace BOMBERG, GERMANY (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business AT HOME.

FATHER
12. Name ? SCHOENLEIN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant AUGUST SAAL (SON)
(b) Address 608 S. FAGLEY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location 4300 BELAIR RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3685 Fait Ave.

JUL 17 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 15, 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1943 to July 15 1945, and that I last saw h[illegible] alive on July 14 1945.

Immediate cause of death	Duration
(a) Cerebral Embolism	1-7-43
Due to (b) Myocarditis	7-1-45
Due to (c) Congestive Failure	7-14-45
Due to (d)	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations: None.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Injs. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Schmeisser M. D.
Address 842 E. East Ave. Date signed 7-16-45

G30794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G30794 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: The Church Home + Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Bengl Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Beever

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife deceased.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-27-1858

8. AGE: Years	Months	Days	If less than one day
86	7	12	hr. min.

9. Birthplace Havre de Grace, Maryland (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business —

FATHER
12. Name James Beever
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Gough
15. Birthplace Maryland.

16 (a) Informant Walter Beever (Son)
(b) Address 3207 Evergreen Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave

18 (a) Funeral director Harry C. Miller Inc
(b) Address 2465 E. Oliver St

19 JUL 17 1945 (Date rec'd by registrar) (b) Huntington Northwood, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 1945 to 7-15 1945, and that I last saw him alive on 7-14-45 1945.

Immediate cause of death Carcinomatosis (Generalized) — Duration

Due to Adenocarcinoma of Sigmoid

Due to

Other Conditions Prostatic hypertrophy. Generalized Arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operations —

Of autopsy Adenocarcinoma of sigmoid with metastasis to regional lymph nodes, liver & mesenteric lymph nodes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M.D.
Address The Church Home + Hospital Date signed 7-15-45

G30795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122

Registered No. G30795

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Hildz Heckner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1895

8. AGE: Years	Months	Days	If less than one day
50	1	11 12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Herman

13. Birthplace Upshur Co. W. Va.

MOTHER 14. Maiden Name Anna Tephner

15. Birthplace Baltimore Md.

16 (a) Informant Louis C. Heckner

(b) Address 2600 Llewellyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Pimlico Road

18 (a) Funeral director John E. Miller

(b) Address 3435 E. Oliver St.

19 JUL 17 1945 (Date rec'd by registrar) Huntington Hillcrest

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15 1945, at 7:40 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1945, to 7-15 1945, and that I last saw her alive on 7-15 1945.

Immediate cause of death Aspiration Pneumonia — Duration 3 days

Due to Operation for Ventral Hernia Lipectomy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-13-45

Major findings of operation: Vent. Hernia

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.

Address Bon Secours Date signed 7-15-45

VS 150

G30796 Fredericka Rethschulte

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30796

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fredericka Rethschulte
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Frederick Rethschulte
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1 1869
8. AGE: Years 76 Months 2 Days 15 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business
FATHER 12. Name Warren Schroeder
13. Birthplace Germany
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Henry Rethschulte
(b) Address 3724 Hudson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Wilkens Ave
18 (a) Funeral director John E Pudley Inc
(b) Address 2435 E Pleasant St
19 JUL 17 1945 (Date rec'd by registrar) (b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 10 15 A M
21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 15 1945 and that I last saw h alive on July 6 1945

Immediate cause of death	Duration
Arteriosclerosis, C.V. Disease	2 days
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 542 S Eutaw Date signed 7-16-45

VS 150

G30797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G30797 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Remington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
Male	C.	

6 (b) Name of husband or wife Fannie.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	6	hr. min.

9. Birthplace Baltimore County, Md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Daniel Price.
13. Birthplace A. A. Co. Md

MOTHER
14. Maiden Name Ellen Sharp Price
15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Fannie Price
(b) Address 2827 Remington Ave

17 (a) Burial (b) Date thereof July 17, 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) JUL 17 1945 (b) Huntingtown Williams, MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1945 at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1945 to 7-14 1945 and that I last saw h/ he alive on 7-14 1945

Immediate cause of death	Duration
2 Uremia	
Malnutrition	
Due to - Carcinoma of stomach	
+ carcinoma of Intestines	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-7-45

Major findings of operation: - Generalized Carcinomatosis

of autopsy: - Generalized Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J Kelly

Address 1700 N Caroline Date signed 7/17/45

VS 180

G30798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56

G30798 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John.
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Brookwood Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ethel Leona Dutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Edgar Eugene Dutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/21/1895

8. AGE: Years	Months	Days	If less than one day
50	2	25	hr. min.

9. Birthplace Sheran Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Horatio Bingham
13. Birthplace Pa

MOTHER
14. Maiden Name Stella Williams
15. Birthplace Sharon Pa

16 (a) Informant Edgar L. Dutton
(b) Address 5309 Brookwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Rochester N.Y.

18 (a) Funeral director A. Donald Evans
(b) Address 1600 S. Charles St

19 (Date received by local registrar) JUL 17 1945 Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1944 to July 16 1945 and that I last saw [illegible] alive on July 16 1945.

Immediate cause of death Metastatic Carcinoma (probably) of Breast — Duration 15 yrs

Due to Carcinoma of Breast amputated 15 years ago

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton
Address Hosp. for Women Date signed 7/16/45

X

G30799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 S. Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Born
(e) Length of stay in Baltimore (yrs., mos., or days) Boyes

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Hanover Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert B George

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1857

8. AGE: Years 87 | Months 8 10 | Days 16 | If less than one day hr. min.

9. Birthplace Kent Co., Delaware (Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business American Oil Co.

FATHER
12. Name John N. George
13. Birthplace Kent Co., Delaware

MOTHER
14. Maiden Name Mary E. Husbands
15. Birthplace Kent Co., Delaware

16 (a) Informant Mrs. Grace Bell
(b) Address 1318 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Denton Bentley
Location Caroline Co. Md.

18 (a) Funeral director A. Raymond Evans
(b) Address 140 S. Howard St Huntingdon Williams, Md

19 JUL 17 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945 at 1 25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Proctor M.D.
Medical Examiner.
Date signed July 16 1945

G30800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G30800 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 164
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 W Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fredrick H. Bauman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-77

8. AGE: Years 73 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Henry Bauman

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Mary Stromeyer

MOTHER 15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19th (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Rural

18 (a) Funeral director Welsh Funeral Home

(b) Address 2108 Orleans St

19 (a) JUL 17 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1945 to July 16 1945 and that I last saw h alive on July 16 1945

Immediate cause of death Pyelonephritis Bilateral

Due to Septicemia

Due to

Other Conditions Congestive Heart Failure

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration: 1 wk | 1 wk | 1 yr (?)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George H Strong

Address J H H Date signed 7/17/45

VS 150

G30801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 176 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. LOUISE PENNING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 4, 1874

8. AGE: Years	Months	Days	If less than one day
71	2	12	hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name JACOB STREIB
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MR. JOHN E DREYER
(b) Address 3014 Northern Pkwy, City

17 (a) ~~Removal~~ Burial (Burial, cremation, or removal) (b) Date thereof July 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem. Co.
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eutaw Pl. Baltimore, Md.

19 (a) Date received by registrar JUL 17 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 5:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945, to July 16 1945 and that I last saw her alive on July 15 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul J. Cimera M. D.
Address U.M.H. Date signed 7/16/45

VS 150

G30802 Anna Ittner G30802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1700 Crystal Ave.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1700 Crystal Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Ittner ITTNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Alfred Ittner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 12 1880

8. AGE: Years	Months	Days	If less than one day
64	8	3	hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Conrad Wunderlich

13. Birthplace Germany

MOTHER 14. Maiden Name Reppel

15. Birthplace Germany

16 (a) Informant Alfred P. Ittner

(b) Address 1700 Crystal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18th (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem Catonsville

Location

18 (a) Funeral director Ulrich Funeral House

(b) Address 2008 Pennsylvania Ave

19 (a) JUL 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 15 1945 and that I last saw h alive on July 10 1945.

Immediate cause of death Diabetic Coma. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. Wesley Rodgers M. D.

Address St. Joseph's Hosp. Date signed July 15

VS 150

G30803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Holle 126

G30803 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4616 Lombard & Redwood
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Arabia Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elizabeth Holle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name William Holle
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Walter R Whitelock
(b) Address 3723 Gibbons Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Cem
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 12 1945 to Jul. 13 1945 and that I last saw h[illegible] alive on Jul 13 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Acute cholangitis,	
Ileus; Cholecystostomy.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Jul 13 45
Major findings of operation: Acute cholecystitis cholelithiasis; ileus.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Butler M.D.
Address Univ. Hosp. Date signed Jul 15

VS 150

G30804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30804

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 S. Macon St DOA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 S. Macon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Maxwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1889

8. AGE: Years	Months	Days	If less than one day
55 Yr.	8	17	hr. min.

9. Birthplace Ill. (Town, county, and state)

10. Usual Occupation Machinist-Upper Fitter foreman

11. Industry or business Sever Bros.

FATHER
12. Name Harlan H. Maxwell
13. Birthplace Ill

MOTHER
14. Maiden Name Ella Kennedy
15. Birthplace Ill

16 (a) Informant Buchanan Funeral Home
(b) Address Robinson Ill.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory Robinson Ill.
Location Ill

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) Date received by Local Registrar JUL 17 1945 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Autopsy thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D J Schmidt M.D. Medical Examiner.
Date signed 7/17/45

G30805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G30805

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 431 N.Robinson St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 431 N.Robinson St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine (May) Smith

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Seperated

6 (b) Name of husband or wife Geo. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.25.1892

8. AGE: Years	Months	Days	If less than one day
52	7	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Struben

13. Birthplace Czecho Slovakia

MOTHER 14. Maiden Name Mary--------

15. Birthplace Czecho Slovakia

16 (a) Informant Mrs. Barbara Soellner

(b) Address 431 N.Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Balto. Md.

18 (a) Funeral director Philip Stewig Sons

(b) Address 2024 Orleans St.

19 Date received JUL 17 1945 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 22 1945 to 7-9- 1945 and that I last saw h[illegible] alive on 7-9- 1945.

Immediate cause of death	Duration
Cardiac Hypertrophy	1944
Arteris Sclerosis	1944
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature T. A. Nicholson M. D.

Address 2270 Eutaw Pl. Date signed 7/17/45

VS 150

G30806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 452

G30806 Registered No. 53107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 3 mo. 21 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr. 3 mo. 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Market Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcelino Sanchez Castro

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1890

8. AGE: Years	Months	Days	If less than one day
55	5	12 13	hr. min.

9. Birthplace Spain (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafaring

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records - U. S. Marine Hospital
(b) Address Baltimore 11, Maryland

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory [illegible] John 2
Location Edgewood Rd

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) 7/17 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH July 13 1945, at 7:15 M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1944, to July 13 1945, and that I last saw him alive on July 13 1945.

	Duration
Immediate cause of death Aspiration pneumonia	2 wks
Due to	
Due to	
Other Conditions Carcinoma base of tongue and pharnyx (Include pregnancy within 3 months of death)	1 yr 8 mo

Date of operation Tracheostomy 4/16/45 Gastrostomy 5/29/44
Major findings of operation
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/17/45
Baltimore 11, Maryland.

VS 150

G30807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

172

G30807

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Indiana (b) County
(c) City or town Westport
(If outside city or town limits, write RURAL and give town)
(d) Street No. Market St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Beasley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Technician

11. Industry or business U.S.A.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory Westport
Location Indiana

18 (a) Funeral director Lilly & Zachary
(b) Address 403 S. Holliday St

19 (Date) 7 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945, at 10 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-16-45 at 9 30 A.M. P.M. 26/6
(b) Where did injury occur? Steamship Stanford Pier "6" Canton St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fall from deck into hold

23. Signature [illegible] M.D. Medical Examiner.

Date signed 7-16-1945

G30808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30808
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Mary Mc Cafferty
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Samuel J. McCafferty
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	3	hr. min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Gardner
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Bevans
15. Birthplace Md.

16 (a) Informant Miss Dorothy B. Gardner
(b) Address 705 Newington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 JUL 17 1945 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16/1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8/1945 to 7/16/1945.
and that I last saw her alive on 7/16/1945.

Immediate cause of death	Duration
Cardiac failure	
paralysis Agitans	
Due to Chronic arteria sclerosis (G-U-D)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Rosen M.D.
Address St. Agnes Hosp. Date signed 7/18/45

VS 198

X

G30809 HINKS ✓ G30809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 W Lanvale (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Hinks, Miss Inyzie Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Rev. Edwin S. Hinks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1859

8. AGE: Years	Months	Days	If less than one day
86	5	28	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name David Funsten
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan Meade
15. Birthplace Virginia

16 (a) Informant Randolph Hame
(b) Address 1314 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ivy Hill
Location Alexandria, Va.

18 (a) Funeral director John O. Mitchell & Son, Inc.
(b) Address 1900 Eutaw Place

19 (a) Date received JUL 17 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16 1945, at 8:29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1945 to July 16 1945 and that I last saw ~~her~~ alive on July 16 1945

Immediate cause of death Chronic cardiac decompensation

Due to Hypertensive Arteriosclerotic Heart disease.

Due to

Other Conditions Fracture-inter-trochanteric - lt femur.
(Include pregnancy within 3 months of death)

Date of operation 7-9-45

Major findings of operation: Intertrochanteric fracture - lt.

of autopsy:

Duration
13 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide accident Cath. Co.
(b) Date of occurrence July 3 1945 at ? M
(c) Where did injury occur? Upperco, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? bedroom While at work?
(Specify type of place)
(e) Means of injury fell from stool

23. Signature Emily Play M. D.
Address Church Home & Hosp. Date signed 7-16-45

Approved: Robert Lee Graham X M.D.

G30810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30810 Registered No. 1314

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonette Grisino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29th 1873

8. AGE: Years	Months	Days	If less than one day
71 72	10	16	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Giennith
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Genovese
15. Birthplace Italy

16 (a) Informant Mr Grisino
(b) Address 619 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Brook
(b) Address 1701-03 N Patterson Park Ave

19 (a) Filed by registrar (b) Registrar Huntington Williams, MD

JUL 17 1945

788 N. Linwood Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15th 1945, at 10:16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945, to July 15 1945, and that I last saw him alive on July 15 1945

Immediate cause of death Cerebral Hemorrhage
Cardio-Vascular-Renal Dis.
Duration 7/15/45

Due to arterial Hypotension + sclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Thos F. Sweeney M. D.
Address 722 N. Linwood Date signed 7/16/45

G30811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87D

Registered No. G30811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light St.
(c) Hospital or institution: So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1466 Woodall ST.
(If rural give location)
(e) Citizen of foreign country? MD (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred E. Yowell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married.

(b) Name of husband or wife Maddeus Yowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-1911

8. AGE: Years 34 | Months 6 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Parsley
13. Birthplace

MOTHER
14. Maiden Name Estella Ray
15. Birthplace

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20 1945 (month) (day) (year)
(c) Cemetery or crematory Ft Lincoln
Location Wash. D.C.

18 (a) Funeral director J. Arthur Walters
(b) Address 207 Carroll ST NW Wash DC

19 (a) (Date received by Registrar) JUL 17 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to July 16 1945, and that I last saw deceased alive on July 16 1945

Immediate cause of death Acute Multiple Sclerosis.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger M.D.
Address 1213 Light St Date signed 7-17-45

VS 180

X

G30812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G30812

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cleveland & Raynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. Furrow St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Ida A. Voos (Stoos)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernard J. Stoos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 1, 1892

8. AGE: Years 52 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Finger
13. Birthplace: Germany

MOTHER
14. Maiden Name:
15. Birthplace: Germany

16 (a) Informant: Bernard J. Stoos
(b) Address: 219 S. Furrow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Md.

18 (a) Funeral director: George W. Lukehart
(b) Address: 2101 Frederick Avenue

19 (a) (b) Registrar

JUL 19 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at 3 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/45 1945, to July 15 1945, and that I last saw her alive on July 15 1945.

Immediate cause of death: Coronary thrombosis

Due to: Arteriosclerosis

Due to: Bronchopneumonia

Other Conditions: Rectal abscess and rectal carcinoma

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Rudolph Baldwin

Address: West Baltimore General Hospital Date signed 7/15/45

C30813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 93D

C30813

Reg. Dist. No. _____

1. PLACE OF DEATH:

County _____

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 415 W. 23rd St

Hospital, institution, or street address where death occurred: 17

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County _____

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 415 W. 23rd St (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME James P. McCann

3. (b) Social Security Number _____

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	S.

6.(b) Name of husband or wife _____ 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 28 - 1860

8. AGE: Years	Months	Days	If less than one day
85	3	17	____ hrs. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Retired

11. Industry or business _____

FATHER 12. Name Michael McCann

13. Birthplace Ireland

MOTHER 14. Maiden name Anna L. Webb

15. Birthplace Pa.

16. Informant Mrs Mary E. Harmison

Address 415 W. 23rd St.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7-18-45 (month) (day) (year)

Cemetery or crematory Mt. Cath.

Location _____

18. Funeral director L. J. Rusk

Address 5305 Harford Rd.

19. JUL 18 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1945, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/2/44 1944, to 7/14/45 1945

and that I last saw h_____ alive on July 14, 1945

Immediate cause of death Coronary Thrombosis — DURATION 4 days.

Due to Arteriosclerotic Cardiovascular Disease

Due to Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE A. Weiss, MD M. D. or other

Address 2902 Huntington Ave Date signed 7/17/45

G30814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 122B

Registered No. G30814

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Bath~~ Towson Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Normal Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [illegible] Smith (Mary Ridgely)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4. 1903

8. AGE: Years	Months	Days	If less than one day
41	11	18 12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Alexander Preston
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Norris
15. Birthplace Maryland

16 (a) Informant Miss Mary Gallagher
(b) Address Same

17 (a) Burial (b) Date thereof July 18/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Johns
Location Ellicott City Md

18 (a) Funeral director Henry W. Hutchins & Sons
(b) Address Ellicott City Md

19 (a) JUL 18 1945 Huntington Williams M.D.
(Date Rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16/1945 at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14/1945 to 6/16/1945 and that I last saw her alive on 6/15/1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Bronchopneumonia	
Due to Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/14/45

Major findings of operation: Intestinal obstruction & gangrene

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Conrad M. D.
Address U-M-H. Date signed 7-16-45

VS 150

X

G30815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G30815

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Phyllis Lillian Chaney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1941

8. AGE: Years 3 yrs. | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Schoolgirl

11. Industry or business

FATHER
12. Name Philip J. Chaney, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Barbara Elizabeth Armiger
15. Birthplace Baltimore, Md.

16 (a) Informant Parents
(b) Address 2317 E. Federal Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/45 (month) (day) (year)

(c) Cemetery or crematory ~~XXXXX~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

JUL 18 1945 (Date rec'd by Registrar) (b) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16 1945 at 5-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1945 to 7-16 1945 and that I last saw h. alive on 7-16 1945.

Immediate cause of death Dehydration, Shock
Due to Pneumonia
Due to Burns and wounds of face, hands, arms.
Due to Dehydration
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-12-45 at 1 00 P.M.
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? Burned leg
(e) Means of injury - Hot water

23. Signature Eva [illegible] Raley
Address 1400 N Caroline Date signed 7/16/45 M. D.

Approved: Robert Lee Dunbar M. D.

VS 150

G30816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G30816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. 29th St., City (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Kilchenstein

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 215-05-6663

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Gertrude Rosalie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	2	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Paper Cutter - Receptionist

11. Industry or business: McCormick's

FATHER
12. Name: John Joseph Kilchenstein
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Catherine Schilling
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Gertrude Kilchenstein
(b) Address: 613 E. 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Baltimore, Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601 E. Madison Street

19 JUL 18 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945, at 12:30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/2

(a) Date of injury 10:45 A.M. 7-16-45
(b) Where did injury occur? 2900 blk. Greenmount Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Fell from porch to ground

23. Signature Robert Lee Gallagher M.D. Medical Examiner.
Date signed July 16 1945

VS 151

G30817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G30817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4625 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Resnick, [redacted] ANNA

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business

FATHER
12. Name Louis Kaufman
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Old Rd & Rowlen Lane

18 (a) Funeral director Jack Segal Inc
(b) Address 1439 E Baltimore

19 (a) JUL 18 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945, at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1945 to 7-13 1945, and that I last saw her alive on 7-13 1945.

Immediate cause of death Gastro intestinal hemorrhage — Duration
Due to Rupture of aorta
Due to Chronic Mediastinitis
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome R. Warlem M. D.
Address Sinai Hospital Date signed 7-13-45

96

VS 150

G30818

Sorge

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G30818

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Harford Rd.
(b) Street address 2920 Hary. Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Hary Rd. (If rural, give location)
(e) Citizen of foreign country? Harford (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Christian Sorge

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Amalia Sorge
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 16. 1879

8. AGE: Years 66 | Months 4 | Days - | If less than one day ... hr. ... min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Christian Sorge
13. Birthplace Germany?

MOTHER
14. Maiden Name Dorothy
15. Birthplace Germany

16 (a) Informant Mrs. Amalia Sorge
(b) Address 2920 Hary. Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18, 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director L. Heemann & Son
(b) Address 32 S. Broadway.

(c) JUL 18 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1935 to July 14 1945 and that I last saw h.i.m. alive on July 14 1945

Immediate cause of death Coronary Occlusion — Duration 7/14/45

Due to Arteriosclerotic Cardio-vascular Disease — ?

Due to W.H. Coronary sclerosis. — ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carey Rostring M. D.
Address 326 W. Lombard St. Date signed 7/16/45

G30819

JO #92167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G30819

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Park Avenue
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Hom Ont

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	?	Male	Yellow	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1887

8. AGE: Years	Months	Days	If less than one day
58	-0-	-2-	hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unable to obtain information.
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart & Monument Co
(b) Address 108-20 North Eutaw

19 JUL 18 1945 Huntington Williams M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 16, 1945, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 16, 1945, to July 16, 1945, and that I last saw him alive on July 16, 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H B Copeland Jr.
Address Balto. City Hosp. Date signed 7/18/45 M.D.

X

G30820

HEALTH DEPARTMENT—CITY OF BALTIMORE

G30820

CERTIFICATE OF DEATH

X 195 B

1. PLACE OF DEATH Kernan Hospital

Registered No.

CITY OF BALTIMORE: (No. Windsor Mill Rd, Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred #? yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Mary Virginia Mengel

If U. S. Veteran specify WAR

(a) Residence: No. Bellevue, Md St., Ward. Somerset Apts.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. Color or Race: white

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year): 4/9/35

7. AGE: Years 10; Months 3; Days 8; If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Md.

FATHER

13. NAME: George Mengel.

14. BIRTHPLACE (city or town) (State or country): Dont know

MOTHER

15. MAIDEN NAME: Dont know

16. BIRTHPLACE (city or town) (State or country): Dont know

17. INFORMANT: Hospital records

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place: Rehoboth Md Date: 7/20, 1945

19. UNDERTAKER: Ulrich Funeral Home

(Address): 2008 Eutaw Place, Baltimore, Md

Registrar

JUL 18 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 7/17/45, 19

22. I HEREBY CERTIFY, That I attended deceased from 7/2, 1945, to 7/17, 1945

I last saw her alive on 7/17, 1945. Death is said to have occurred on the date stated above, at 4:40 p.m.

The principal cause of death and related causes of importance were as follows:

Shock during anesthesia (cardio-respiratory failure). — Date of onset 7/17/45

Other contributory causes of importance:

Was an operation performed? yes Date of 7/17/45

For what disease or injury? Decapsulation of old poliomyelitis

Name of operation Decapsulation of the anterior horns

What test confirmed diagnosis? Post. Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 7-17, 1945

Where did injury occur? Kernan Hospital (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place public

Manner of injury Died during anesthesia

Nature of injury Anesthesia

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Dr. A. Cattaneo M. D.

(Address) Dec. Apptmt. Kernan Hospital

Robert L. Graham M.D. 7/18/45

N. B.—WRITE PLAINLY, WITH UNFAILING INK—THIS IS A LEGAL DOCUMENT. The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G30821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30821

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Walkin + Eutaw Aves

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3223 Strickland St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country Ireland

3 (a) FULL NAME John Mc Namara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1880

8. AGE: Years	Months	Days.	If less than one day
65	2	13	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Mfg Cigarstory

FATHER 12. Name Patrick McNamara

13. Birthplace Ireland

MOTHER 14. Maiden Name Nora Farrell

15. Birthplace Ireland

16 (a) Informant Mrs James

(b) Address 1428 Mosby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-[illegible]-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Bath Md

18 (a) Funeral director Geo A Farley

(b) Address Tudor & Fayette

19 (a) 7-18-1945 Huntington Williams M.D. Registrar

(b) Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945 at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 AM 1945 to 7/16 PM 1945 and that I last saw h[illegible] alive on 7/16 1945

Immediate cause of death Coronary occlusion — Duration 1 day

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Alleva M.D.

Address Date signed 7/16/45

VS 150

G30822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30822

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 W Lexington st.
(c) Hospital or institution: 181
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore — (23)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 W. Lexington
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Emma Tolson Woodville

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: widowed.
6 (b) Name of husband or wife: James J. Woodville
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 25, 1888
8. AGE: Years 56 | Months 11 | Days 20 | If less than one day — hr. — min.
9. Birthplace: Albany, Georgia (Town, county, and state)
10. Usual Occupation: Day worker Domestic
11. Industry or business: Domestic Service

FATHER
12. Name: Warren Tolson
13. Birthplace: Liverpool, England

MOTHER
14. Maiden Name: Penden Howard
15. Birthplace: Nile River, Africa

16 (a) Informant: Ruby Lee Bailey
(b) Address: 934 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/45 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l. Pk.
Location: Baltimore County, Md.

18 (a) Funeral director: Charles H. Cooper
(b) Address: 512 N. Carrollton Ave

19 (a) 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 July 1945 at 1:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4. 13. 1945 to 7. 16. 1945 and that I last saw he[r] alive on 7. 15. 1945.

Immediate cause of death: congestive heart failure. — Duration 6.30.45
Due to: Cardio-renal-vascular disease — 1943
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: James M. Lair M. D.
Address: 400 N. Carrollton Ave Date signed 7-16-45

VS 2

G30823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30823 / 1220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 Lafayette St.
(c) Hospital or institution Dr. A. Balt. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Hudson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Schuner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Harry Schuner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/74

8. AGE: Years	Months	Days	If less than one day
70 11	11	8 >3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Marion Dilatz
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Mowes
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Pickett
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Glen Green Balto. Co. Md.

18 (a) Funeral director John A. Hilby
(b) Address 2634 Jefferson St.

19 (a) (Local registrar) (b) Huntington Williams, M.D.

JUL 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to July 14 1945, and that I last saw h.w.k. alive on July 16 1945.

Immediate cause of death Heart failure — Duration

Due to Intestinal Obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Large orbital hernia - strangulated

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold K. Mowbray M.D.
Address Dr. A. Balt. Gen. Hosp. signed 7/14/45

X

G30824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√ 51 B

Registered No. G30824

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Mulberry St Town
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 75
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Mulberry St Town
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME John M Keller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary E Keller
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) 5 17 1865

8. AGE: Years	Months	Days	If less than one day
80	1	29	hr. min.

9. Birthplace Washington DC (Town, county, and State)
10. Usual Occupation Printer
11. Industry or business Printing

FATHER
12. Name Geo Keller
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Mount
15. Birthplace Ireland Md

16 (a) Informant Mary E. Keller
(b) Address 521 Mulberry St Town

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Bernard A Funk
(b) Address 2463 Belair Rd

19 July 18 1945 (b) Date received by Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945, at 4.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945 to 7/14 1945 and that I last saw him alive on 7/14 1945.

Immediate cause of death abdominal carcinomatosis — Duration 6 mos.

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Grayton
Address 2463 Glenmount Ave Date signed 7/17/45

VS 180

G30825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1348

G30825

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Rine

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Nora Wright Rine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1870

8. AGE: Years 74 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John W. Rine
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Catherine Lease
15. Birthplace Frederick, Md.

16 (a) Informant Miss Ethel V. Rine
(b) Address 803 Woodington, Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/45 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11/45 to 7/17/45 and that I last saw him alive on 7/17/45.

Immediate cause of death Pulmonary Embolus

Due to Post Operative Super Pubic Prostatectomy

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 7/13/45

Major findings of operation: Hypertrophied Prostate; Stone in Bladder

of autopsy: none

Duration: 7 days hospital stay

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 7/17/45

VS 150

G30826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30826

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — In auto outside of:
(b) Street address 2221 Bryant Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Auchentoroly Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfredo H. Fernandez

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 190-09-1628

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline J. Fernandez

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1899

8. AGE: Years	Months	Days	If less than one day
46	1	5	hr. min.

9. Birthplace: Montreal, Canada (Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Electrolux Corp.

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Pauline J. Fernandez
(b) Address: 3102 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUL 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1945 at 10 57 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D. Medical Examiner.
Date signed July 17 1945

VS 151

G30827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G30827

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Caroline Sts
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Emma B. Hammond.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/79.

8. AGE: Years	Months	Days	If less than one day
65 yrs	8	13 3	hr. min.

9. Birthplace Balto Maryland.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Francis H. Hammond
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Caroline Gunther
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Francis A. Hammond
(b) Address 2323 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945 at 7.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1945 to 7/16 1945 and that I last saw h.e.r alive on 7/16 1945.

Immediate cause of death Respiratory Failure

Due to Bilateral Basilar Pneumonia

Due to

Other Conditions Chronic Cholecystitis & Lithiasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral Pneumonia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Edmonds M. D.
Address St. Joseph's Hosp. Date signed 7/16/45

X

G30828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. G30828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town ~~Dundalk~~ Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 583 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Volandt

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Bertha Volandt
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) June 28, 1883

8. AGE: Years	Months	Days	If less than one day
62 ~~yrs~~		18	hr. min.

9. Birthplace Canada (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Volandt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Moot
15. Birthplace Germany

16 (a) Informant Mrs. Mary E. Depkin -sister
(b) Address Severna Park, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 18 1945 (Date received) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945, at 10 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Ten Grotian M.D. Medical Examiner
Date signed July 18 1945

G30829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30829 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Grandison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Mechanic's Helper

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Eunice Grandison
(b) Address 1828 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott, Dft
(b) Address 1299 N. Caroline St.

19 (a) JUL 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Elliott M.D.
Medical Examiner.
Date signed July 16 1945

VS 151

G30830

JO #94671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 a

Registered No. G30830

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1945

8. AGE: Years	Months	Days	If less than one day
			6 hr. 23 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Waverly Williams
13. Birthplace Washington

MOTHER
14. Maiden Name Helen Williams
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremated 9am (b) Date thereof 7-17-1945 (month) (day) (year)
(Burial, cremation, or removal)
(c) ~~Cemetery~~ or crematory Baltimore City Hospital
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) 7-18-1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1945, at 11:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11-1945 to 7-11-1945, and that I last saw him alive on 7-11-1945

Immediate cause of death	Duration
Interacranial Hemorrhage	6½ hr.
Due to Birth Injury	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. B. Reese, Jr., M.D.
Address Balto City Hosp. Date signed 7/16/45

VS 150

G30831 Donnon X 9 G30831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hammondi Lane (Brooklyn) (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Richard Carter Donnon

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/2/45

8. AGE: Years	Months	Days	If less than one day
	2	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Paul Donnon (Keyser W. Va.)
13. Birthplace Keyser, W. Va.

MOTHER
14. Maiden Name Olive Springer
15. Birthplace Westernport Md.

16 (a) Informant Olive Donnon
(b) Address Hammondi Lane (Brooklyn)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Gor. Ritchie Highway

18 (a) Funeral director Mattox Schilling
(b) Address 3914 E. Hamburg St (25)

19 (a) (Date rec'd by registrar) (b)
JUL 18 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 1945, at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1945 to 7/17 1945, and that I last saw h/M alive on 7/17 1945.

Immediate cause of death Respiratory failure — Duration —
Due to Pertussis — Duration 7 days
Due to H. pertussis — Duration —
Other Conditions Broncho-pneumonia — Duration 6 days
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 7/17/45

G30832 T.N. 94299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No. G30832

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Willis Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5th. 1922

8. AGE: Years 22 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Aaron Holloway (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Jennie Brooks (D
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 18 1945 (b) (Must be filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21st 1945, to July 2 1945 and that I last saw h... alive on July 2 1945.

Immediate cause of death: respiratory failure — Duration 30 Min

Due to: post anesthetic

Due to: for circumcision for phimosis — 11 days

Other Conditions: Syphilis, early latent granuloma inguinale
(Include pregnancy within 3 months of death)

Date of operation 7-2-45

Major findings of operation: granuloma inguinale with phimotic foreskin

of autopsy: none Autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 2 1945 at 2:30 P M
(c) Where did injury occur? Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Anesthesia

23. Signature Kenneth L Blum M.D.
Address Balto City Hosp. Date signed 7-13-45

TO BE APPROVED BY MEDICAL EXAMINER

Robert L. Von Lee M.D.

VS 150

X 2843

G30833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30833 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Le Roy Owens
13. Birthplace

MOTHER
14. Maiden Name [illegible] Haywor th
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 18 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945 to July 1 1945, and that I last saw him alive on July 1 1945

Immediate cause of death prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh
Address Johns Hopkins Hospital Date signed 7-5-45 M.D.

F-834

G30834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30834 Registered No. 1122a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) About 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Mrs. Katherine S. Walsh

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jefferson J. Walsh
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 21, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	26	-- hr. --- min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name William H. Baer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth A. Cherry
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Katherine S. Walsh
(b) Address 2725 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

(c) 7 18 1945 (Date received by registrar) (d) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) 7-17 1945 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1945 to 7-17 1945 and that I last saw her alive on 7-17 1945.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Strangulated Femoral Hernia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-15-45
Major findings of operation: Strangulated Hernia
of autopsy: Gangrenous Intestine

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Williams M. D.
Address 1400 N. Caroline St. Date signed 7-17-45

VS 130

G30835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G30835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2530 Dulaney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Louise Channels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife X

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) June 17, 1945

8. AGE: Years	Months	Days	If less than one day
	1	-	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Walter N.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Cora Hildreth
15. Birthplace West Virginia

16 (a) Informant Parents
(b) Address 2530 Dulaney St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 7/19/1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) JUL 19 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1945 to 7/17 1945 and that I last saw her alive on 7/17 1945.

Immediate cause of death	Duration
Hyaline membrane	
cardio Respiratory failure	
Due to prematurity	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Robert, M.D.
Address St. Agnes Hosp. Date signed 7/17/45

X

G30836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30836

4812

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Berrett (If outside city or town limits, write RURAL and give town)
(d) Street No. R D Sykesville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Minnie Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband ~~or wife~~ Ruddy Fleming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1894

8. AGE: Years	Months	Days	If less than one day
50 51	0	2	hr. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Columbus A Conaway
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ida B. Pickett
15. Birthplace Maryland.

16 (a) Informant Hospital Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Westfield, Carroll Co. Md.

18 (a) Funeral director C. M. Lewis
(b) Address Westfield, Md

19 (Date received by Registrar) JUL 19 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19 1945, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to July 19 1945, and that I last saw h[illegible] alive on July 19 1945.

Immediate cause of death Cardiac failure

Due to embolic obstruction

Due to generalized carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 12, 1945

Major findings of operation: generalized carcinomatosis

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R. Callender M. D.
Address University Hosp. Date signed 7-19-45

VS 180

G30837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. G30837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 S.GLOVER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S.GLOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ETHEL ANNA LINTHICUM

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.22 1905

8. AGE: Years 39 41 | Months 10 11 | Days 26 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation SALES LADY

11. Industry or business BONNET LENNON CO.

FATHER
12. Name CONRAD M.WEBER
13. Birthplace BALTO.

MOTHER
14. Maiden Name MARGARET OTT
15. Birthplace BALTO.

16 (a) Informant MARGARET WEBER (MOTHER)
(b) Address 709 S.GLOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 20/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S.WOLFE ST.

19 JUL 19 1945 (Date rec'd by registrar) (b) Huntington Wm Registrar

VS 150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH JULY 17 1945, at 5/10M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 17 1945 and that I last saw h. alive on July 17 1945

Immediate cause of death: Generalized Carcinomatosis 2 mos
Due to Carcinoma of liver with
metastasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 1945
Major findings of operation: Carcinoma of liver with metastasis
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Louis J. Ruth M. D.
Address 1001 E. Fayette St. Date signed 7/18/45

G30838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G30838

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Rayner + Rutland Sts.
(c) Hospital or institution: West Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 d.

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Brooklyn
(c) City or town Route #9 Balto. 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME BABY BOY KLOHR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1945

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William George Klohr
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Myrtie Tillis
15. Birthplace Florida

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 19 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1945 to 7/15 1945.
and that I last saw h alive on 5/15 1941.

Immediate cause of death PNEUMONIA

Due to ATELECTASIS

Due to INTRACRANIAL HEMORRHAGE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ehrenfeld M. D.
Address West Balt. Gen. Hosp. Date signed 7/15/45

VS 180

2844

G30839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G30839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Four Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Division st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Maurice Cloud

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-9-45

8. AGE: Years	Months	Days	If less than one day
		4	7 hr. min.

9. Birthplace Balts. md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norman Delmas Cloud
13. Birthplace Chester, S.C.

MOTHER
14. Maiden Name Cora Lee Bradham
15. Birthplace Olar, S.C.

16 (a) Informant Cora Lee Cloud
(b) Address 1203 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or Location UNIVERSITY MEDICAL SCHOOL JUL 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 19 1945 Huntington Williams M.D.
(Registered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1945, to 7-14 1945, and that I last saw h.m alive on 7-13 1945.

Immediate cause of death

Due to Pneumothorax

Due to Congenital Atelectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Sutter M. D.
Address Forest Heights Date signed 7/17/45

1-846

G30840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G30840 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr 50min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Ething St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-16-45

8. AGE: Years	Months	Days	If less than one day
			1 hr. 50 min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George E. Mills
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Florence Heigh
15. Birthplace Lower Marlboro Co. Md

16 (a) Informant George E. Mills
(b) Address 2221 Ething St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 19 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16 1945, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1945 to 7-16 1945, and that I last saw h[illegible] alive on 7-16 1945.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pendleton M. D.
Address Cumberland Md. Date signed 7/17/45

VS 150

2845

2858 Hartford Ave JOHNS G30841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30841

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 Montpelier st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Montpelier st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roy B Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Edna C
6 (c) If alive, give age 48y

7. Birth date of deceased (mo., day, yr.) Nov 13 (1897)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	7	3		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Insurance agt
11. Industry or business

FATHER
12. Name Wm J Johns
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Allendale
15. Birthplace Md

16 (a) Informant Mrs Roy B Johns
(b) Address 1446 Montpelier st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director George A Farley
(b) Address Fulton & Laydetas

JUL 19 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to July 16 1945 and that I last saw h[illegible] alive on July 15 1945

Immediate cause of death	Duration
Hypertensive cardiovascular disease	48 hrs
Due to Nephritis Regurgitation	2 yrs
Due to Interstitial nephritis Chronic	6 mos
Other Conditions Contributory.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred A Zimmerman M. D.
Address 2858 Hartford Ave Date signed 7-17-45

VS 150

G30842 Findel ✓ G30842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 S Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 S Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Findal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1892

8. AGE: Years	Months	Days	If less than one day
53	11	15	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Harris

13. Birthplace Md

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Md

16 (a) Informant Elizabeth Fowlkes

(b) Address 532 W Lee Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore Md

18 (a) Funeral director Sarah L Brown Jr

(b) Address 1811 Monty omery St

19 (a) JUL 19 1945 (Date received by Registrar) (b) Huntington Willis Jr M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 45, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to July 16 1945, and that I last saw her alive on July 14 1945.

Immediate cause of death: Chronic Cardio-renal disease — Duration: about 4 mo.

Due to: unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John W Haines

Address 507 W. Hamburg St Date signed 7/18/45 M. D.

X

G30843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

G30843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 E. Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 51 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sarah B. O'Connor

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph P. O'Connor
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 8, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	9	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lawrence Dempsey
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Kennedy
15. Birthplace Ireland

16 (a) Informant Joseph P. O'Connor (Husband)
(b) Address 1415 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

JUL 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17th 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from JUN 18 1945 to JUL 17 1945, and that I last saw her alive on JUL 15 1945

Immediate cause of death	Duration
Cerebral Hemorrhage or Embolism	14 hrs
Due to Hypertention & Endocarditis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: X X X
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify (b) type of place) While at work? X X
(e) Means of injury

23. Signature Otto H. Duker M.D.
Address 786 North Ave. Date signed 7/18/45

G30844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30844

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edelwood & 33rd
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland, County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3233 Abell Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MICHAEL FILIPPI (Michael Filippi)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-05-2266

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: KatherineRosenauer

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1881

8. AGE: Years 63 | Months 6 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Barber-shop

FATHER
12. Name Peter Filippi
13. Birthplace Hungary

MOTHER
14. Maiden Name Schmidt
15. Birthplace Hungary

16 (a) Informant Bernard M. Filippi (Son)
(b) Address 3233 Abell Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JUL 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/45 19 ..., at 6:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ■ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 7/17/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G30845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2326 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josie C. Duckett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1885

8. AGE: Years 59 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Prince Geo. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Duckett

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Magruder

15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Goodrich

(b) Address 2326 Madison Ave

17 (a) Burial (b) Date thereof July 19, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodstock Mem. Pk.

Location Balt. Co. Md.

18 (a) Funeral director Mrs. Geo. H. Hayland

(b) Address 1625 Druid Hill Ave

19 (a) JUL 19 1945 (b) Huntington for Williams, Mgr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945 at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16, 1945 to July 15, 1945 and that I last saw her alive on July 13, 1945.

Immediate cause of death	Duration
(a) Veterans	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell

Address 718 Dolphin St. Date signed 7-18-45 M. D.

VS 150

G30846

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G30846
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Mount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name John Price
13. Birthplace Md.

MOTHER
14. Maiden Name Martha E. Travers
15. Birthplace Maryland

16 (a) Informant Mrs. Ella Price
(b) Address 616 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Hubbard
(b) Address 1631 Druid Hill Ave

19 (a) July 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1945, at 8 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral embolism
Cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frazier M.D.
Medical Examiner.
Date signed July 16 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30847

AB-94644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G30847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Harriet Ann Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18- 1863

8. AGE: Years	Months	Days	If less than one day
82	0	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER 12. Name Andrew White

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Henrietta White

MOTHER 15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1945 (Month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee A. Holland

(b) Address 1631 Druid Hill Ave.

19 JUL 19 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 17- 1945, at 11.50M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1945, to 7-17 1945, and that I last saw h... alive on 7-17- 1945.

Immediate cause of death: Bronchopneumonia — Duration 48 hrs

Due to: Coronal Failure

Due to: Arteriosclerotic Heart disease

Due to:

Other Conditions: Arteriosclerosis Gangrene Lt + Foot

(Include pregnancy within 3 months of death)

Date of operation 7-12-45

Major findings of operation: Arteriosclerosis Gangrene Lt + foot

of autopsy: Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Barry M.D. M. D.

Address Baltimore City Hosp Date signed 7/17/45

G30848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G30848

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace W

MOTHER
14. Maiden Name Unknown
15. Birthplace W

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)

(c) Cemetery or crematoty
Location Leonardtown, Md.

18 (a) Funeral director Pius B. Robinson
(b) Address Dameron, Md. Huntingtown Williams, Md.

19 (a) JUL 19 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17 1945 at 7 43 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 to 1945
and that I last saw him alive on 1 wk prior to death 1945

Immediate cause of death Unknown

Due to Carcinoma of stomach with massive metastases to Liver.

Due to

Other Conditions Arteriosclerosis, Scarred Kidney ? Gumma
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas A. Vence MD
Address Johns Hopkins Hosp Date signed 7/18/45

Approved: Robert Lee Graham M.D. 7/19/45

VS-150

G30849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G30849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 Clemmus ave
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3600 Keene Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Sommer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1941

8. AGE: Years 1 | Months | Days 11 | If less than one day hr. min.

9. Birthplace North Attleboro - Mass
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name John Sommer Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Corinne Mayer
15. Birthplace Md.

16 (a) Informant Mr. John Sommer Jr.
(b) Address 3600 Keene Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location

18 (a) Funeral director L. J. Rocks
(b) Address 5305 Harford Rd

19 JUL 19 1945 (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17 1945, at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1945 to 7-17 1945 and that I last saw her alive on 7-17 1945

Immediate cause of death	Duration
Toxemia	
Due to generalized peritonitis following operation for	
Due to intestinal obstruction -	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-16-45

Major findings of operation: Intestinal obstruction - Meckel -

of autopsy:

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Callender Jr. M. D.

Address Univ. Hosp. Date signed 7-17-45

VS 150

G30850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1126

Registered No. G30850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Chateau Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Leopold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W divorced

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	22	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Thomas O'Rourke
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Rourke
15. Birthplace Ireland

16 (a) Informant Mrs Leon J. Rinker
(b) Address 513 Chateau Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location

18 (a) Funeral director Leonard J. Rinker
(b) Address 5305 Harford Rd.

19 (a) JUL 19 1945 (Date received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18 1945 at 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1945 to 7-18 1945, and that I last saw her alive on 7-18 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pneumonia + Shock	
Due to Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-16-45

Major findings of operation: - Obstruction of small intestine - due to gallstones

of autopsy:

PHYSICIAN Underline the cause to which death is to be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin L. Rider M. D.
Address 1400 N Caroline St Date signed 7-18-45

VS 150

G30851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30851

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1046 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eugenia Bell Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/1890

8. AGE: Years	Months	Days	If less than one day
55		29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md

MOTHER
14. Maiden Name Anna Bausell
15. Birthplace Md

16 (a) Informant Mary Bell
(b) Address 1046 W. Saratoga St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. Co. Md

18 (a) Funeral director Williams & Jackson
(b) Address 966 Penna ave

19 JUL 19 1945 (Date rec'd by registrar) (b) Registrar

Funeral for Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 17 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral hemorrhage	4 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Wells
Address 512 Lemington Date signed 7/19/45

X

G30852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G30852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 Harlem ave
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Harlem ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1871
8. AGE: Years 74 Months Days If less than one day hr. min.
9. Birthplace Hanover Va. (Town, county and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Robert Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Julia Jones
(b) Address 816 Harlem ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location
18 (a) Funeral director Ebron A. Wilson
(b) Address 1000 Bentley ave
19 (a) (b) Registrar
Rec'd by registrar 7/19/45
Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1945, at 4:45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1945 to 7/16 1945, and that I last saw h alive on 7/16 1945.

Immediate cause of death Carcinoma Colon — Duration
Due to Obs. Endocarditis + Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hamilton Williams M. D.
Address Date signed

7/19/45

G30853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (-937)

Registered No. G30853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 Wyman Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Wyman Parkway
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Mary Agnes Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John E. Carroll
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	10	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Laurence Molloy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Jane Kirkland
15. Birthplace Baltimore, Maryland

16 (a) Informant John E. Carroll
(b) Address 2928 Wyman Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) JUL 19 1945 (Date received) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945, at 8:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from ---- 19-- to ---- 19--, and that I last saw h-- alive on ---- 19--.

Immediate cause of death	Duration
Hypertensive Heart failure	6 Mos
Due to Extreme Hypertension	2 years +
Due to ?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Removal of Kidney - Dec 1944
Major findings of operation:
of autopsy: ----

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature L. Harrell Pierce, M.D.
Address 312 Med. arts Bldg Date signed 7/19/45

VS 150

(over) X

G30854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114-D

Registered No. G30854

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: UNION MEMORIAL HOSPITAL 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12da.

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2004 Mt. Royal Terrace (If rural give location)

(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME Oliver Stewart Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-10-7355

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Elizabeth B. Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1902

8. AGE: Years	Months	Days	If less than one day
43	3	9	hr. min.

9. Birthplace WASHINGTON, D.C. (Town, county, and state)

10. Usual Occupation Accounting Clerk.

11. Industry or business

FATHER 12. Name B. L. Anderson

13. Birthplace Maryland

MOTHER 14. Maiden Name Jenkie Stewart

15. Birthplace MONTANA.

16 (a) Informant Mrs. Elizabeth B. Anderson

(b) Address 2004 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem. Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received by registrar JUL 19 1945 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 17 1945 and that I last saw him alive on July 17 1945.

Immediate cause of death	Duration
Cardiac Failure?	
Due to Post-operative	
Due to Pneumonectomy - 1st stage	
Other Conditions. Lung abscess RT. lower lobe.	

(Include pregnancy within 3 months of death)

Date of operation July 17, 1945

Major findings of operation: Adhesions, pneumothorax.

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. D. Garrett III M. D.

Address Union Memorial Hosp. Date signed 7-19-45

VS 150

The G30855

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 48a

Registered No. G30855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Fairview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N Y (b) County Warren
(c) City or town Glens Falls
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilla A Gourley

3 (b) If veteran, name war W/
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Norman R
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1875

8. AGE: Years 69 | Months 3 | Days - | If less than one day: hr. min.

9. Birthplace Withville Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Hauser
13. Birthplace Germany

MOTHER
14. Maiden Name Lilla Duchbmon
15. Birthplace Germany

16 (a) Informant Norman R Gourley
(b) Address 35 0 Fairview Ave
17 (a) Burial Thursday (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory Glens Falls
Location Glens Falls N Y
18 (a) Funeral director Wilbur Co Inc
(b) Address 219 Ft Ann St
19 (a) Date received JUL 19 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 11.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945 to July 16 1945 and that I last saw h[illegible] alive on July 14 1945.

Immediate cause of death: Kidney block about — Duration: 2 days

Due to Primary extensive carcinoma of the cervix xxx and metastasis in the surrounding tissues. From history — 6 mo.

Other Conditions — about

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles S. Niblett Blvd. M. D.
Address 222 Harrison Date signed July 16/45 X

VS 180

G30856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1578

Registered No. G30856

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N Fayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-45

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Isaac Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Clara Byrd
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Md.

18 (a) Funeral director Archibald E. Hayden
(b) Address 2101 McCulloh St.

19 (a) JUL 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1945 to 7-18 1945 and that I last saw him alive on 7-18 1945.

Immediate cause of death: Meningitis — Duration: 2 days
Due to: Septicaemia
Due to: Ruptured Infected Meningocele — 5 days
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena A. Hall, Asst. Res.
Address Hopkins Hosp. Date signed 7-18-45 M.D.

VS 150

X

G30857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 Pulaski St
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Pulaski St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Charles Wesley Updyke

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Millie O.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) March 23 1870

8. AGE: Years 75 | Months 3 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Mill Hand
11. Industry or business retired

FATHER
12. Name Cannon Updyke
13. Birthplace Va

MOTHER
14. Maiden Name Louise Baggerly
15. Birthplace Va

16 (a) Informant Mrs Willie O. Updyke
(b) Address 2016 Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22 45 (month) (day) (year)
(c) Cemetery or crematory Savage
Location Savage Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md

19 (a) JUL 19 1945 (Date received) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 18 1945 and that I last saw h. alive on July 18 1945.

Immediate cause of death Cerebral arterio sclerotic cardio vascular disease — Duration 6 mos

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Benjamin Millan M. D.
Address 2056 Wilkens Ave Date signed 7/16/45

630858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 630858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Knof

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 19 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th, 1945, at 1:30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutman M.D.
Medical Examiner.
Date signed July 8 1945

F2851

G30859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G30859
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Eutaw
(c) Hospital or institution: Maryland Rural Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
Street No. 914 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Mary Ellen Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name J. Morris Green
FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Ellen Ridgely
MOTHER 15. Birthplace Maryland.

16 (a) Informant C. Edwin Green
(b) Address 404 Greenwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Rd

18 (a) Funeral director Harry A. Wiktor
(b) Address 4101 Edmondson Ave

(a) JUL 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/45 19 , at 4.10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

John C. Davis M.D.
Medical Examiner.

23. Signature
Date signed 7/14/45

X

G30860 45
354

Weitzen

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G30860

CERTIFICATE OF DEATH V 106 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Braddock (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Washington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Weitzen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-28

8. AGE: Years	Months	Days	If less than one day
17	6	16	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adolph Weitzen
13. Birthplace Austria

MOTHER
14. Maiden Name Bertha Wernberger
15. Birthplace Austria

16 (a) Informant Rose
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-19-45 (month) (day) (year)
(c) Cemetery or crematory Braddock, Pa
Location Jack Lewis Inc

18 (a) Funeral director 1439 E Balt St.
(b) Address

19 (a) 7-19-1945 (Date received by local registrar) (b) Huntington Williams, Md. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1945 to 7-19 1945. and that I last saw h alive on 7-19 1945.

Immediate cause of death Hemorrhage — Duration

Due to Operation

Due to Bronchiectasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/7/45 7/19/45

Major findings of operation: Bronchiectasis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rudolph H. Kaufmann M. D.
Address Johns Hopkins Hosp. Date signed 7-19-45

VS 150

G30861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G30861

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 ALICEANNA ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM SEITZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARGARET SEITZ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 9 1884

8. AGE: Years	Months	Days	If less than one day
60	11	10	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation TRANSFER BUSINESS
11. Industry or business FOR SELF

FATHER
12. Name JOHNSEITZ
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ROSE WUSHNAK
15. Birthplace GERMANY

16 (a) Informant MARGARET SEITZ (WIFE)
(b) Address 1826 ALICEANNA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 23/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Selby & Zeller
(b) Address 403 S. WOLFE ST.

JUL 20 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH JULY 19 1945 at 8/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to July 19 1945, and that I last saw h[illegible] alive on July 19 1945.

Immediate cause of death: Acute Lob. Pneumonia — Duration: 7 days
Due to Primary
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Seitz M. D.
Address 700 E. Pratt St. Date signed 7/20/45

G30862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

G30862 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. Belnord Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 & 2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert D. Kidwell

3 (b) If veteran, name war W.W.# 2

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MARGARET KIDWELL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 26 1906

8. AGE: Years 39 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace CUMBERLAND MD. (Town, county, and state)

10. Usual Occupation PLUMBER

11. Industry or business

FATHER
12. Name ADAM P. KIDWELL
13. Birthplace VA.

MOTHER
14. Maiden Name NORA RICE
15. Birthplace MD.

16 (a) Informant MARGARET KIDWELL (WIFE)
(b) Address 102 N. BELNORD AVE.

17 (a) BURIAL (Burial, cremation, or removal) **(b) Date thereof** JULY 23/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Leilly & Zeller Inc.
(b) Address 403 S. WOLFE ST.

19 (a) JUL 20 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Thrombosis of left Iliac Vein

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gaston M.D. Medical Examiner.
Date signed July 19 1945

G30863 SMALKIN ✓ G30863

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

119a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Lombard & Greene Sts
(b) Street address ~~1-2 Sudbrook Lane~~
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mths.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 2 Sudbrook Lane
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Barry Smalkin ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6/45

8. AGE: Years	Months	Days	If less than one day
0	6	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business none

FATHER
12. Name H Richard Smalkin
13. Birthplace Md.

MOTHER
14. Maiden Name Sadye M Kellert
15. Birthplace Md.

16 (a) Informant mother
(b) Address 12 Sudbrook Lane Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location Loth Lane ave

18 (a) Funeral director Sol Levinson Bro
(b) Address 1124-26 W North Ave

19 July 20 1945 (b) Huntington Williams, M.D.
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 10:17 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 19 1945 and that I last saw h.. alive on July 19 1945

Immediate cause of death	Duration
Dehydration	5 days
Due to Infectious Diarrhea	6 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. T. Rowland

Address University Hospital Date signed M. 7 D. 20/45

VS 180

X

G30864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G30864
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1945

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Joseph Rogers
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Ruth Shaw
15. Birthplace North Carolina

16 (a) Informant J.H.H. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 20 1945 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 19 45 to July 14 19 45, and that I last saw him alive on July 14 19 45

Immediate cause of death ? Pneumonia — Duration

? Congenital heart disease

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed 7-17-45

2854 X

G30865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

✓ G30865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Fawn St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1012 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RITA CECELIA FOLIO

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	215-18-9167	F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/28/1922

8. AGE: Years	Months	Days	If less than one day hr.	min.
22	9	21		

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Leonard Folio
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Margaret Geiger
15. Birthplace Balto., Md.

16 (a) Informant Miss Theresa Geiger
(b) Address 1012 Fawn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 20 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 19 43 to 7/19 1945, and that I last saw her alive on 7/18 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence M. Lenz
Address 41 E. Chase St. Date signed M/D. 7/20/45

VS 150

X

G30866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30866 Registered No. 467

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Shaughnessy SHAUGHNESSY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 31, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	18	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business Ship Yard

FATHER
12. Name Edward Shaughnessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Gertrude Chantaine
15. Birthplace Baltimore Md

16 (a) Informant Emma Shaughnessy
(b) Address 2121 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Pullen & Leary
(b) Address 1214 E Lanvale St

19 JUL 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1942 to July 19 1945 and that I last saw ~~him~~ alive on July 19 1945.

Immediate cause of death Bronchopneumonia — Duration 4 days
Due to Carcinoma Recti — 2 mos?
Due to Metastases Intestinal obstruction
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Karl Grossman M. D.
Address 1212 N Patterson Date signed 7/19/45

Phcare

VS 150

G30867 G30867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 N. Greene Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude A. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/1915

8. AGE: Years	Months	Days	If less than one day
29	11	19	hr. min.

9. Birthplace Gambrills, Md (Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Unknown

FATHER
12. Name John H. Lewis
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Maughlin
15. Birthplace Md

16 (a) Informant John H. Lewis
(b) Address 311 N. Greene St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory Baldwin Memorial Church
Location Stevin Cross Rds. A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(Address) 610 St Paul St.

19 (a) JUL 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1945, at 6 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 17 1945

VS 151

Hollamon

G30868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G30868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 860 W. Pratt St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 3
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 860 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen H Hollamon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Vossie T
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): June 17, 1919
8. AGE: Years: 26. Months: 1 Days: 2 If less than one day hr. min.
9. Birthplace: Kansas City, Mo. (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: at home

FATHER
12. Name: Albert Pollock
13. Birthplace: Cartersville, Ga

MOTHER
14. Maiden Name: Greenfuing
15. Birthplace: New York

16 (a) Informant: Mr. Vossie T Hollamon
(b) Address: 860 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet Cem
Location: 29 Frost Rd

18 (a) Funeral director: John J Cowan Son
(b) Address: 400-03 Hollins St

19 (a) Jul 20 1945 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1945 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 10 1945 to July 19 1945.
and that I last saw her alive on July 18 1945.

Immediate cause of death: Carcinoma of Uterus — Duration: 4 mo
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature: [illegible] M. D.
Address: [illegible] Date signed 7/19/45

VS 150

G30869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G30869 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 E. 28th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 E. 28th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGEANNA NAGLE

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles F. Nagle
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1859

8. AGE: Years 86 | Months 5 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John W. Caskey
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Dunn
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr & Mrs Walter Louder
(b) Address 1826 E 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21,45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] (b) (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH July 19 1945, at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945, to July 19 1945, and that I last saw her alive on July 18 1945.

Immediate cause of death	Duration
Bronchus Pneumonia	2 d.
Marasmus	2 d.
Due to Arteria Sclerosis	8 d
Hypertension	8 d
Due to Chronic Interstitial Nephritis	8 d
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation No.
Major findings of operation: No.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S F A Stevens M. D.
Address 2878 Hartford Rd Date signed 7-19-45

VS 150

X

630870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Reg. No. 630870

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1718 Johns Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1

(e) Length of stay in Baltimore (yrs., mos., or days) 68-9-14

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1718 Johns St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow.

6 (b) Name of husband ~~or wife~~ Marion E. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1876

8. AGE: Years 68 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Howard

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Annie Hall

15. Birthplace Baltimore Md

16 (a) Informant Clara Howard

(b) Address 1718 Johns Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Patterson & Sons

(b) Address 4324 Liberty Heights

19 (a) 7/20/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1939 to July 1945 and that I last saw her alive on July 9 1945

Immediate cause of death	Duration
Due to Myocardial Dis. Chr	6 yrs
Due to Cardio. vascular disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles F. Wenzel

Address M.D. Arts Bldg Date signed 7-21-45 D.

VS 150

G30871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G30871

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hosp. 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country France

3 (a) FULL NAME Sister Mary Ermelinda SSND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1868

8. AGE: Years 77 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business Teacher

FATHER
12. Name Joseph Stadler
13. Birthplace France

MOTHER
14. Maiden Name Teresa Kammengieser
15. Birthplace Germany

16 (a) Informant Sister of Notre Dame
(b) Address 901 Aisquith

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Glen Arm

18 (a) Funeral director Geo. M. Fritz & Son
(b) Address 811 N. Wolfe St.

19 (a) JUL 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19 1945 at 7 23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1945 to 7-19 1945 and that I last saw her alive on 7-19 1945.

Immediate cause of death: Respiratory Failure — Duration

Due to: Bronchial Pneumonia — Duration

Due to: Hypertensive C.V.D. Diabetes Mellitus Arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 7-19-45

VS 150

G30872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 954 Forrest St.

(c) Hospital or institution: Maryland Penitentiary

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2 27

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 413 North Fulton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Patrick Murphy

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Charlotte Murphy

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 9, 1904

8. AGE: Years	Months	Days	If less than one day
41	3	11	hr. min.

9. Birthplace Corsica, N.Y. (Town, county, and state)

10. Usual Occupation Garage proprietor

11. Industry or business

FATHER 12. Name Patrick Murphy

13. Birthplace Dublin, Ireland

MOTHER 14. Maiden Name Elizabeth Foley

15. Birthplace Vermont

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hyde Rd.

18 (a) Funeral director D. J. Foley Sons

(b) Address 1818 Light St.

19 (c) 7-20-1945 (Date received by local registrar) Thurlington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1944, to July 20 1945, and that I last saw him alive on July 20 1945.

Immediate cause of death: Dislocation of 5th cervical vertebra — Duration

Due to: Execution by hanging

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joe C. Carras M. D.

Address Medical Arts Bldg. Date signed 7-20-45

C30873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C30873

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5841 York Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara T. Kerr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Robert L. Kerr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1855

8. AGE: Years	Months	Days	If less than one day
89	7		hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Henry Reid
13. Birthplace England

MOTHER
14. Maiden Name Anne White
15. Birthplace England

16 (a) Informant Henry A. Kerr
(b) Address 700 E. 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JUL 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945, at 3:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1935 to July 18 1945.
and that I last saw her alive on July 14 1945

Immediate cause of death: Uraemia Coma — Duration: 7 days
Due to Chr. Interstitial Nephritis — years ?
Due to Generalized arteriosclerosis — 15 years ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Draught M. D.
Address 10 E. Biddle St. Date signed

G30874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

§3a

Registered No. G30874

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Homewood Apts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: none
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: Homewood Apts. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country:

3 (a) FULL NAME: Mary Eudora Wilen

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 11, 1855

8. AGE: Years	Months	Days	If less than one day
90	1	8	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: John Oliver Wilen
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Esther M. Mahon
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Andrew P. Spamer
(b) Address: Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory: Stone Chapel
Location: Reisterstown Road, Balto. Co., Md.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 JUL 20 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from - - 1945 to 7/19/ 1945, and that I last saw h[illegible] alive on 7/19/45 19

Immediate cause of death	Duration
Cerebral hemorrhage	2 wks.
Due to Arteriosclerosis & hypertension	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robt. B. Wright M. D.
Address: Medical Arts Bldg. Date signed: 7/20/45

Dr. Robt. B. Wright

VS 150

G30875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G30875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 N. Schroeder Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Edward Raiford Hutchinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bessie McDevitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-1921

8. AGE: Years	Months	Days	If less than one day
23	10	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business 620 W. Lexington St.

FATHER
12. Name James Hutchinson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Parker
15. Birthplace Baltimore, Md.

16 (a) Informant Rose Parker - mother
(b) Address 244 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23 1945 (month) (day) (year)

(c) Cemetery or crematory Western Star Cemetery Catonsville Baltimore County

18 (a) Funeral director Joseph A. Sirdy
(b) Address 4199 Mount Street

19 JUL 20 1945 Huntingtown Williams, M.D. (Date received by City Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 1:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds of Head, Neck & Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-18-45 at 1:05 A. M.
(b) Where did injury occur? S.W. cor. N Schroeder & Saratoga Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shooting

23. Signature Raul La Grotta M.D. Medical Examiner.
Date signed July 19 1945

VS 151

G30876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30876 ✓ Registered No. 937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Scott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Pabst

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	~~Divorced~~

6 (b) Name of husband or wife Rose Pabst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26. 1880

8. AGE: Years	Months	Days	If less than one day
64	10	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Varnisher
11. Industry or business F. X. Gautier - show Cases

FATHER
12. Name Theodore F. Pabst
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Valle
15. Birthplace Germany

16 (a) Informant William Pabst
(b) Address 5221 Linden Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) JUL 20 1945 (Date rec'd by registrar) (b) July 20 1945 Huntington Maryland

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to July 19 1945 and that I last saw him alive on Jan 19, 1945

Immediate cause of death Acute Heart Failure — Duration

Due to Hypertensive Vascular Heart Disease

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Clavius M. D.
Address 876 Wolfe St Date signed

× 7/29/45

G30877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G30877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ORIGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Sherwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanor L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1908

8. AGE: Years 37 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Western Electric Co.

FATHER
12. Name Thomas Mitchell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Agnes Hubbard
15. Birthplace Balto Md.

16 (a) Informant Eleanor Mitchell
(b) Address 1913 Sherwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Wm Cob Inc
(b) Address 1717 St Paul St

19 (a) JUL 20 1945 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945 at 3 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6 3A

(a) Date of injury 7-20-45 at M.
(b) Where did injury occur? Oldham & Holabird Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by switch engine of Canton R.R.

23. Signature M.D.
Date signed July 20 1945

VS 151

G30878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G30878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 S. Bouldin Street
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 S Bouldin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward A. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Catherine Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1892

8. AGE: Years	Months	Days	If less than one day
S.T. 52	9	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business Continental Can Co.

FATHER
12. Name John Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John Johnson (Son)
(b) Address 1100 S. Bayliss st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Extended

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) JUL 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1945, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gutman M.D. Medical Examiner.
Date signed July 19 1945

VS 151

G30879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 14

G30879 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Hartford Rd.

(b) Street address ~~1912 Lowellyn Ave.~~

(c) Hospital or institution: Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balt

(c) City or town Balt.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1712 Lowellyn Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A.? — years

3 (a) **FULL NAME** Ethel Lee Fennell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) not known

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation cleaning woman

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Steph Finnell

15. Birthplace North Carolina

16 (a) Informant

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 20/45 (month) (day) (year)

(c) Cemetery or crematory

Location Garland N. Carolina

18 (a) Funeral director Mrs. Robert G. Elliott Sr.

(b) Address 1129 N. Caroline St.

19 (a) ~~JUL 20 1945~~ Huntington Williams, Md.

(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16 1945, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945, to July 16 1945, and that I last saw h er alive on 7-16 1945.

Immediate cause of death	Duration
Tuberculous meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret H. D. Smith M. D.

Address Sydenham Hosp. Date signed 7/17/45

VE 3

X

G30880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30880 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Annabel Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Annabel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Durm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife (Nee Egner) Catherine R. Durm
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 27, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business Own Business

FATHER
12. Name Charles Durm
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia A. Robinson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine R. Durm (Wife)
(b) Address 508 Annabel Ave. (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location A. A. Co., Md.

18 (a) Funeral director E. Howard Evans
(b) Address 1400 E. Chase St. (30)

19 (a) JUL 20 1945 Huntington Williams, M.D. Registrar
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945, to July 20 1945, and that I last saw h[illegible] alive on July 20 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent M. Mearing
Address 1403 S. Charles St Date signed 7/20/45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G30881 — Houpe ✓ — G30881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G30881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 649 Dover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 649 Dover street
(If rural give location)
(e) If foreign born, how long in U. S. A.? ——— years

3 (a) FULL NAME Katie Dunlap Houpe

3 (b) If veteran, name war ———

3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	widowed

6 (b) Name of husband or wife Lee Houpe

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) March 18, 1877

8. AGE: Years	Months	Days	If less than one day
68	4	29	hr. ——— min.

9. Birthplace Statesville, N. Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ———

FATHER
12. Name Mike Dunlap
13. Birthplace Statesville, N.C.

MOTHER
14. Maiden Name Jane Tuck
15. Birthplace Statesville, N.C.

16 (a) Informant Mrs. Belle Cunningham
(b) Address 649 Dover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary.
Location ———

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 327 N Schroeder St

19 (a) JUL 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 July 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 June 1945 to 17 July 1945 and that I last saw her alive on 16 July 1945.

Immediate cause of death ———
Myocarditis
Due to ———
Due to ———
Other Conditions ———
(Include pregnancy within 3 months of death)

Major findings:
Of operations ———
Of autopsy ———

Duration
6-29-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ———
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ———
(e) Means of injury ———

23. Signature James M. Carr M. D.
Address 406 N. Carrollton Ave. Date signed 7-18-45

G30882 H-2297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G30882

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Johns Hopkins Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 N Duke and Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Deborah ~~Keilla~~ (DEBORAH JOYCE KIELLA)

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1945

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Peter ~~Keilla~~ (Kiella)

13. Birthplace ~~Finland~~ Michigan

MOTHER 14. Maiden Name MARION Melendy

15. Birthplace ~~Finland~~ Florida

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 21, 1945 (month) (day) (year)

(c) Cemetery or crematory Wauchula Cemetery

Location Wauchula, Florida

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave.

19 (a) July 20 1945 Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 — 1945, at 1 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17- 1945 to 7-18 1945, and that I last saw her alive on 7-18 1945

Immediate cause of death	Duration
Cardiac Decompensation	1 day
Due to Congenital Malformation	—
Due to of heart	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena S. Hall Asst Res

Address Hopkins Hospital Date signed 7-18-45 M.D.

X

G30883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G30883

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5106 Litchfield ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 Litchfield ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie H. Price

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Morris Price
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 23-1876
8. AGE: Years 68 | Months 8 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Charles Guild
13. Birthplace Va

MOTHER
14. Maiden Name Clara Handy
15. Birthplace Mass.

16 (a) Informant Mrs. Elizabeth Griffin
(b) Address 5106 Litchfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto Md

18 (a) Funeral director Geo L Berry Jr.
(b) Address 1512 Hollins St

19 (a) JUL 20 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945, to July 19 1945, and that I last saw h[illegible] alive on July 18 1945.

Immediate cause of death: Hypertension Paralysis left side — Duration: unknown

Due to:

Due to:

Other Conditions: Hypertensive Coronis — July 18/45

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H A Dorsey M. D.
Address 817 Medical Arts Bldg Date signed July 19/45

G30884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30884

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2662 Wilkins Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2662 Wilkins Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Constantine E. Fitzsimmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary A. Fitzsimmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19 - 1863

8. AGE: Years	Months	Days	If less than one day
84	6	-	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Constantine Fitzsimmons

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Rogers

15. Birthplace Md

16 (a) Informant Miss Ella E. Sheppard

(b) Address 2662 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director J. B. Shipperd & Son

(b) Address 850 W. Baltimore St.

19 (a) 21 1945 (Date received by registrar) (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19/1945 12:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/19 1945

that I last saw h alive on 7/19 1945.

Immediate cause of death Arterio-sclerotic cardio-vascular disease

Duration
6 mons

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 207 N. Wilkens Ave Date signed 7/20/45

VS 180

G30885

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

G30885 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 Grantley street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Grantley street
(If no st. give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE I. JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife George Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1856

8. AGE: Years	Months	Days	If less than one day
89	5	9	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James Sutton
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Catherine I. Locke
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Joseph A. Kendrick
(b) Address 618 Grantley street

17 (a) Burial (b) Date thereof 7/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Anne's
Location Annapolis, Md.

18 (a) Funeral director Edwin L. Evans Sons Inc
(b) Address 1711 E. Fayette St. Baltimore, Md.

19 (a) [illegible] (b) [illegible]
(Signature of registrar) Registrar

JUL 20 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to July 19 1945.
and that I last saw h[illegible] alive on July 19 1945.

Immediate cause of death Myocarditis

Due to senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature
Address 618 Grantley st Date signed 7/19/45 M.D.

Rebecca Jackson

G30886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G30886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Pine St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Pine St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Thos. Jackson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			min.

9. Birthplace Prince Richard Co. Md. (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Vinney George
13. Birthplace Va.

MOTHER
14. Maiden Name Miley Bass
15. Birthplace Va.

16 (a) Informant Melvin Melvin 22nd
(b) Address 402 N Pine St 22nd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 45 (month) (day) (year)

(c) Cemetery or crematory Patrick-Burgoa Funeral Home, Inc. (Frederick, Md.)

18 (a) Funeral director Leroy O Wilson

(b) Address 1000 Brantley Ave

19 (a) (Local registrar) (b) Registrar

JUL 20 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/45 19 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/45 to 7/17/45 19

and that I last saw her alive on 7/17/45

Immediate cause of death — Duration

(a) Cerebral hemorrhage

Due to: (b) Uremia Nephritis

Due to: (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Slemp M. D.

Address 402 N Pine St Date signed 7/19/45

G30887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30887
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raymer Ave.
(c) Hospital or institution:
W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Wilmington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Sandy Shacklay
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 18, 1945
8. AGE: Years | Months: 1 hr. | Days | If less than one day: hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Jack Shacklay
13. Birthplace Parkesburg, Maryland
MOTHER 14. Maiden Name Frances Sudborough
15. Birthplace Adrian, Michigan.
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 18 1945
18 (a) Funeral director Commissioner of Health
(b) Address
JUL 20 1945 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18- 1945 at 3:40 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1945 to 7-18 1945
and that I last saw her alive on 7-18 1945

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Allen G. Wooden M.D.
Address WBGH Date signed 7-18-45

VS 150

12855

X

G30888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G30888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St. Josephs Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4105 Glenmore Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Thomas J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-92

8. AGE: Years	Months	Days	If less than one day
53	4	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Lupinek

13. Birthplace Balto

MOTHER 14. Maiden Name Mary Sliffka

15. Birthplace Balto.

16 (a) Informant Thomas J. Keating

(b) Address 9105 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Balto. Md

18 (a) Funeral director Patrick Roach Son

(b) Address 900 N. Chester St

JUL 20 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945 to 7-17 1945, and that I last saw her alive on 7-17 1945

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Leucocytosis & hemorrhage.	
Due to Carcinoma of the cervix.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-12-45

Major findings of operation: Carcinoma of cervix

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Eugene J Riley M. D.

Address Date signed 7-17-45

VS 180

C30889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

C30889 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton + Eaton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3402 Beech Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jane Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1861

8. AGE: Years	Months	Days	If less than one day
84	5	16	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs Margaret Gonsack
(b) Address 3402 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant
Location Hamden Md

18 (a) Funeral director Alexander & Hamerman
(b) Address 3610-12 Eastern Ave
(c) Huntington Williams MD (Registrar) Registrar

JUL 20 1945

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945 at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 7/18 1945, and that I last saw her alive on 7/18 1945.

Immediate cause of death Cardiac Failure — Duration

Due to Degenerative Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Dead cell carcinoma 1 gram

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jose D'Alvarez & Chanduvi M. D.

Address Date signed 7/19/45

X

G30890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G30890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2843 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter E. Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kathleen A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1898

8. AGE: Years	Months	Days	If less than one day
47	6	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER 12. Name	James
FATHER 13. Birthplace	Ireland
MOTHER 14. Maiden Name	Frances Ward
MOTHER 15. Birthplace	W. Va

16 (a) Informant Mrs. Walter E. Doyle
(b) Address 2843 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)
(c) Cemetery or crematory Catholic Hgh
Location Bolto Md

18 (a) Funeral director George A. Fuller
(b) Address Fulton & Fayette

19 (a) [illegible] registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Le Gendre M.D. Medical Examiner.
Date signed July 19 1945

JUL 23 1945

AS 151

G30891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163M

Registered No. G30891

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4413 Marble Hall Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott Read Stenger

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen B. Stenger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1908

8. AGE: Years	Months	Days	If less than one day
37	2	7	hr. min.

9. Birthplace Jenkintown, Pa.
(Town, county, and state)
10. Usual Occupation Claim Mgr.
11. Industry or business Century Indemnity Ins. Co.

FATHER
12. Name Thomas E. Stenger
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Hovey
15. Birthplace Waldoboro, Maine

16 (a) Informant Mrs. Helen B. Stenger
(b) Address 4413 Marble Hall Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/20/45 (month) (day) (year)
(c) Cemetery or crematory
Location Waldoboro, Maine

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

20 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1945, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to automobile gasoline fumes
Due to (Carbon Monoxide)
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/19/45 at about 2 P.M.
(b) Where did injury occur? Garage - 4413 Marble Hall Rd
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work?
(d) Means of injury Inhalation of gasoline fumes in closed garage

23. Signature [signature] M.D.
Medical Examiner.
Date signed 7/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PENALTY IMPOSED BY LAW FOR WILFUL FALSIFICATION OR WITHHOLDING OF FINDING

34951 G30892

BALTIMORE CITY HEALTH DEPARTMENT X V G30892
Registered No.

CERTIFICATE OF DEATH 52B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Tampa (If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife W. M. Ritter
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 12-5-15

8. AGE: Years	Months	Days	If less than one day
29	7	14	hr. min.

9. Birthplace Detroit Mich. (Town, county, and state)
10. Usual Occupation home wife
11. Industry or business

FATHER
12. Name Elbert Lamphin
13. Birthplace

MOTHER
14. Maiden Name Blanch Davis
15. Birthplace Michigan

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 24 45 (month) (day) (year)
(c) Cemetery or crematory Tampa Cem. Location Tampa Florida
18 (a) Funeral director Fielbaum & Sons.
(b) Address 20 E. Penn. Aves.
19 1-20 1945 (Date received by registrar) Municia for Williamson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 8:22 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14-45 19 to 7-19 1945 and that I last saw her alive on 7-19 1945

Immediate cause of death Pyelonephritis, bilateral
Abscess, pelvic, left
Abscess, multiple renal, right
Due to post operative course following bilateral ureteral reimplantation (Ectopic Ureters operation)
Other Conditions
(Include pregnancy within 3 months of death)

Duration 2 mos.

Date of operation April 1945
Major findings of operation: Tumor of Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M.D.
Address 839 N. Broadway Date signed 1-20-45 M. D.

VS 150

G30893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30893

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: MERCY Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mon.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mon.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Sharpesburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME TWANNA MARIE EASTERDAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1942

8. AGE: Years	Months	Days	If less than one day
2	7	29	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name CLARENCE EASTERDAY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MABEL PAULINE McQUAY
15. Birthplace VIRGINIA

16 (a) Informant CLARENCE EASTERDAY
(b) Address Sharpesburg, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 22 1945 (month) (day) (year)
(c) Cemetery or crematory Mountainview
Location Shanksville Md

18 (a) Funeral director Edith L. Fast
(b) Address Williamsport Md

19 (Date received) JUL 21 1945 Huntington-Williamsport, M&R

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 20 1945, and that I last saw her alive on July 20 1945.

	Duration
Immediate cause of death Cardiac failure, peripheral vascular collapse.	
Due to Chronic Nephrotic Nephritis with Anasarca.	10 months
Due to	
Other Conditions	

(Include pregnancy within three months of death) Blood

Date of operation Paracentesis 7/5/45

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick M. D.
Address Mercy Hosp., Balto, Md. Date signed 7/29/45

VS 180

G30894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3513 Falls Road
(c) Hospital or institution: at home 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Falls Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William McPhail McCauley.

3 (b) If veteran, name war — ? —

3 (c) Social Security Account No. — 710 —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances McCauley
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 28 1866

8. AGE: Years	Months	Days	If less than one day
79	2	21	hr. min.

9. Birthplace Ellicott City, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business none

FATHER
12. Name John McCauley
13. Birthplace Howard Co. Md

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Ellicott City, Md

16 (a) Informant Frances McCauley (wife)
(b) Address 3513 Falls Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7-21-45 (month) (day) (year)
(c) Cemetery or crematory St Mary's.
Location 3800 Roland Ave

18 (a) Funeral director Stuart-Thompson Co.
(b) Address 108 W North Ave.

19 7 21 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945 to 7/19 1945 and that I last saw him alive on 7/19 1945

Immediate cause of death	Duration
Cerebral Ideus L. Hemiplegia	24 hrs.
Due to Cerebral Arteriosclerosis.	1 yr.
Due to Arterio sclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Peters M. D.
Address 7204 Charles Date signed 7/19/45

VS 150

G30895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G30895 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 N. Spring St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Omar Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1897

8. AGE: Years 47 48 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Whitehaven, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Benjamin Conway
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ellen ?
15. Birthplace Md

16 (a) Informant Ester M. Robinson
(b) Address Salisbury, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/45 (month) (day) (year)

(c) Cemetery or crematory
Location Whitehaven, Md

18 (a) Funeral director Joseph G. Locke
(b) Address 1304 N. Central Ave

19 JUL 21 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 1A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 20 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G30896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Hoffman Sts
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Yorkway Dundalk
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Premature Baby
11. Industry or business —

FATHER
12. Name Arley E. Davis
13. Birthplace Missouri

MOTHER
14. Maiden Name Mary Freese
15. Birthplace Hagerstown, Md.

16 (a) Informant Mary Freese
(b) Address 2913 Yorkway - Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Bakers
Location Charlesville - Harford Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) JUL 21 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1945, to July 19 1945, and that I last saw her alive on July 19 1945.

Immediate cause of death	Duration
Prematurity	
Due to Premature Labor of Uterus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Pahn M. D.
Address Date signed 7/20/45

W 30 97347172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30

Registered No. 60897 S-30897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland JOHN HOPKINS HOSPITAL

(b) Street address

(c) Hospital or inst. [redacted]

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 421-S. SPRING St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie MANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-91

8. AGE: Years	Months	Days	If less than one day
54 53	5	24	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name George Mann

13. Birthplace N.C.

MOTHER 14. Maiden Name Mary Widener

15. Birthplace N.C.

16 (a) Informant records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 20 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 21 1945 (Date rec'd by registrar) Huntington Williamsport, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 13 - 1945 at 2 1/4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29- 1945 to 7-13- 1946 and that I last saw him alive on 7-13- 1946.

Immediate cause of death Ruptured Aortic Aneurysm — Duration

Due to Syphilitic Aortitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means [illegible]

23. Signature William T. Dixon

Address Johns Hopkins Hospital Date signed 7/16/45

VS 150

2856

X

G30898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G30898

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Hiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1858

8. AGE: Years	Months	Days	If less than one day
87	0	9	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name ? Hoffman

13. Birthplace Germany

MOTHER 14. Maiden name Margaret Oaintag

15. Birthplace Germany

16 (a) Informant Margaret Hiller

(b) Address 604 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)

(c) Cemetery Balto

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1212 St. Paul St.

19 (a) JUL 21 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-20-1945 at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1945 to 7-20-1945 and that I last saw her alive on 7-20-1945.

Immediate cause of death Respiratory failure

Due to Bronchial Pneumonia

Anemia

Due to

Other Conditions Fractured Femur (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1

(a) Accident, suicide, or homicide accident

(b) Date of occurrence June 17, 1945 at ? M

(c) Where did injury occur? 604 N. Eutaw St. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury Fell off porch at home.

23. Signature Allen C. Wooden M. D.

Address W.B. & H. Date signed 7-20-45

Approved: Rent Le Fetra M.D.

VS 150

G30899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 St Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Jamie) James Birchenall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen Birchenall
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 6-21-21

8. AGE: Years	Months	Days	If less than one day
24	-	28	hr. min.

9. Birthplace South America (Town, county and state)
10. Usual Occupation Consulate Service
11. Industry or business

FATHER
12. Name Joseph Birchenall
13. Birthplace

MOTHER
14. Maiden Name Alcira Bugas
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Delair Pa

18 (a) Funeral director Clarence P. Hoffman
(b) Address 1639 N Broadway

19 (a) JUL 21 1945 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1945 to 7-19 1945 and that I last saw him alive on July 19, 1945.

Immediate cause of death Streptococcic septicemia + cellulitis

Duration 10 da.

Due to Leukopenia, agranulocytosis, and thrombocytopenia

Other Conditions ? acute myeloid leukemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Graham A. Vence M.D.
Address Johns Hopkins Hospital Date signed 7/19/45

VS 180

G30900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G30900

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5109 St George Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 St Georges ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Theresa Furst

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frederick V Furst

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) Oct 28 1868

8. AGE: Years 76 | Months 8 | Days 22 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Bossle
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary T Gilbert
15. Birthplace Balto

16 (a) Informant Mr. Frederick V Furst
(b) Address 5109 St Georges Rd

17 (a) Funeral Dept. (Burial, cremation, or removal) (b) Date thereof July 23 (month) 45 (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Henry Wenkens Sons
(b) Address McCullough Orchard & Co

19 (a) JUL 21 1945 (Registered by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to July 20 1945, and that I last saw h[illegible] alive on July 19 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Hypostatic Pneumonia	
Due to Endocarditis	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl H Benson M.D.
Address 511 York Rd Date July 20, 1945

VS 180

G30901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G30901 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Alfred R. Riggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Laura L. Riggs
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation lawyer
11. Industry or business

FATHER 12. Name Lawrenson Riggs
13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Mary T. Bright
15. Birthplace Indiana

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 Date received by Local Registrar JUL 21 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 1.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19 1945, to July 20 1945, and that I last saw him alive on July 20 1945.

Immediate cause of death	Duration
respiratory failure	
Due to carcinoma of the bladder	?
Due to metastasis from carcinoma of the prostate	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 7-20-45

VS 150

630902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 630902

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2646 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2646 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John - Oscar - Fearson.

3 (b) If veteran, name war none.

3 (c) Social Security Account No.

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** Married.

6 (b) Name of husband or wife Sue E. Fearson.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14-1881.

8. AGE: Years 64 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Centerville Md.
(Town, county, and state)

10. Usual Occupation Pie Baker.

11. Industry or business "Retired"

FATHER
12. Name Walter Fearson.
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Sarah A. Seward.
15. Birthplace Md.

16 (a) Informant Mrs. Sue E. Fearson.
(b) Address 2646 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** July 23-'45. (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 JUL 21 1945 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July-19th; 1945, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943. to July 18 1945.
and that I last saw him alive on July 19 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension Cardiac Insufficiency	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 25 3 W. Fayette St. Date signed July 22 1945

G30903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G30903 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Longwood St.
(c) Hospital or institution:

16-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Longwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM JAMES MARRIOTT

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Leota M. Marriott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1895

8. AGE: Years	Months	Days	If less than one day
49	9	6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Balto. City.

FATHER
12. Name Wm. C. Marriott
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Sarah East
15. Birthplace Va.

16 (a) Informant Mrs. Leota M. Marriott
(b) Address 713 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Westminster, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 21 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945, to July 18 1945 and that I last saw h[illegible] alive on July 18 1945.

Immediate cause of death: Anaplastic Carcinoma of Small Intestine (Ileum) — Duration: One year

Due to: Anaplastic Carcinoma

Due to: Ca Gross removed from Chest.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation March 25-1945

Major findings of operation: Ca alone

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 2818 St Paul St Date signed 7/26/45

VS 150

X

G30904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR FAILURE TO OBSERVE THIS LAW ARE SUBJECT TO PENALTY OF FINE OR IMPRISONMENT OR BOTH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16
(c) Hospital or institution: Sinai Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Harlan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Weaver

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-03-1234

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma V. Weaver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1877

8. AGE: Years 67 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Retired Salesman

11. Industry or business: Armour & Co.

FATHER
12. Name: Charles Weaver
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Margaret Byer
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Margaret I. Mergehenn
(b) Address: 2304 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

JUL 21 1945 (Date rec'd by Registrar) (b) for Williams, Registrar

MEDICAL CERTIFICATION

55

20. DATE OF DEATH July 20, 1945, at 6 A.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed July 20 1945

VS 151

G30905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G30905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Hickory Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ann Wright

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Emory Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5-1869

8. AGE: Years 76 | Months 3 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name T. Thomas McComm
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Lemmo
15. Birthplace Maryland

16 (a) Informant Harry L. Wright
(b) Address 85 W. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 [illegible] Undertaker for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gaston M.D.
Medical Examiner.
Date signed July 20 1945

JUL 21 1945

VS 151

G30906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30906 Registered No. 1312a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Midwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Midwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Florence Rosensteel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1869

8. AGE: Years	Months	Days	If less than one day
76	5	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business School teacher

FATHER
12. Name Leo Rosensteel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Frances Roberts
15. Birthplace Baltimore

16 (a) Informant Mrs. Edw. Dempsey
(b) Address 5215 Midwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Jul 21 1945 [illegible] Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19-1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1944, to 7-19-1945, and that I last saw her alive on 7-18-1945

Immediate cause of death: Arteriosclerotic cardiovascular disease — Duration: 1 month
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Sybert M.D.
Address 2862 Harford Rd Date signed 7/20/45

G30907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G30907

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 N.Ellwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 N.Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Schwinger

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia Schwinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.22,1874

8. AGE: Years 70 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Schwinger
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Burke
15. Birthplace Germany

16 (a) Informant Mrs. Virginia Schwinger
(b) Address 516 N.Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henrig Sons
(b) Address 2024 Orleans St.

19 Date received JUL 21 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18/45 19..., at 8P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to July 18 1945, and that I last saw h alive on July 18 1945

Immediate cause of death: Coronary Embolism — Duration 7/18/45 — 1hr
Due to: Arterio-Sclerosis + Hypertension — 1yr
Due to: — 1yr
Other Conditions: Bronchial Stasis — 1yr
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumeich M. D.
Address 722 N. Kenwood Ave Date signed July 20/45

VS 150

G30908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. G30908

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp. 15 or 16
(c) Hospital or institution: ↓
Calvert & Saratoga
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 10/60 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 7 10/60 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Walbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Connelly

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/20/45

8. AGE: Years	Months	Days	If less than one day
			7 hr. 10 min.

9. Birthplace Mercy Hosp. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Connelly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Mc Cabe
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director McCabe Lange & Sons
(b) Address 1827 W. North Ave

19 (a) JUL 21 1945 (b) Date rec'd by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21/1945, at 12:24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1945 to 7/21 1945; and that I last saw him alive on 7/21 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to ? ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter K. Shelby M.D.
Address Mercy Hosp. Date signed 7/21/45

VS 150

C30909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C30909

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4716 Dartford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4716 Dartford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Becker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W

6 (b) Name of husband or wife Ida R. Becker
6 (c) If alive, give age (1) years

7. Birth date of deceased (mo., day, yr.) 2/21/1882

8. AGE: Years	Months	Days	If less than one day
63	1	19	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Woodworker
11. Industry or business Ideal Kraft Co.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 4716 Dartford Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)
(c) Cemetery or crematory Westview.
Location Edmondson Ave.

18 (a) Funeral director James L. McCauley
(b) Address 120 E. Fort Ave.

19 (a) JUL 21 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1945, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1945, to 7/20 1945, and that I last saw him alive on 7/16 1945.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Beckwith M.D.
Address 4209 Hood Ave. Date signed 7/21/45

X

G30910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G30910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene Sts.
(c) Hospital or institution: University 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norma Heed

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-1939

8. AGE: Years	Months	Days	If less than one day
5	7	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation child
11. Industry or business none

FATHER
12. Name George Heed
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Birmingham
15. Birthplace Md.

16 (a) Informant Ellen Birmingham Heed
(b) Address 910 Burgundy St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick, Md.

18 (a) Funeral director Jos. L. McCarthy
(b) Address 1307 East Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
JUL 21 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19/45 19 , at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9/1945 19 , to 7-19-1945, and that I last saw h[illegible] alive on July 19 19 45.

Immediate cause of death	Duration
Bronchial obstruction	35 minutes
Due to Lobar pneumonia - Tracheo-Bronchitis	1 day
Due to Streptococcus infection	2 days
Laryngeal diphtheria &	
Other Conditions myocardial failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: (over)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lowell T Hubbard
Address University Hospital Date signed 7/20/45 M. D.

X

G30911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30911

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Fort Ave.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie C. Berner.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Gustave A.
6 (c) If alive, give age (1) years

7. Birth date of deceased (mo., day, yr.) 9/12/1865

8. AGE: Years	Months	Days	If less than one day
79	10	7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 920 E. Fort Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director James L. McCauley
(b) Address 180 E. Fort Ave.

19 (a) (Date received by registrar) Huntington Williams Registrar

JUL 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1942 to July 19 1945, and that I last saw her alive on July 18, 1945.

Immediate cause of death Hypertensive Cardiovascular Renal Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. I. Friedman M.D.
Address 819 Light St Date signed 7/21/45

X

G30912 21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G30912

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cranston Gardens
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 EVANS WAY (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Noble
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-18-2658

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	m

6 (b) Name of husband or wife Myra Noble
6 (c) If alive, give age 190 years
7. Birth date of deceased (mo., day, yr.) 12/24/1[illegible]

8. Age	Years	Months	Days	If less than one day
49	49	6	26	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name M. Noble
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Kinder
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 45 (month) (day) (year)
(c) Cemetery or crematory Dulaney Hill Cem
Location Lutherville Md
18 (a) Funeral director John P. Mitchell & Sons
(b) Address 1908 Eutaw Place
19 (a) Date received JUL 24 1945 (b) Hunting Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 6:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-19- 1945 to 7-20- 1945 and that I last saw h[illegible] alive on 7-20- 1945.

Immediate cause of death Cerebral hemorrhage & subarachnoid hemorrhage — Duration 2 days
Due to Hypertensive cardiovascular disease Syn. —
Due to
Other Conditions Broken nose
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence 7/18/45 at M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work? No
(e) Means of injury
23. Signature Rebecca G. Vance M.D.
Address Johns Hopkins Hospital Date signed 7/20/45

Robert Lee Graham M.D. X (Coroner)

G30913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G30913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & Johns St.

(c) Hospital or institution Women's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2744 N. Calvert St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Annie Thom (Annie C. Thom)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles Wm. Thom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/5/1862

8. AGE: Years	Months	Days	If less than one day
82.	10	16	hr. min.

9. Birthplace Rockford, Ill. (Town, county, and state)

10. Usual Occupation Invalid

11. Industry or business

FATHER

12. Name — Collier

13. Birthplace

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. Nancy Aman

(b) Address 2744 N. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/21/45 (month) (day) (year)

(c) Cemetery or crematory Linwood Cem.

Location Haverill, Mass.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 JUL 22 1945 Huntington Williams, M.D. (Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 7.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 21 1945 and that I last saw s/he alive on July 21 1945

Immediate cause of death Hypostatic pneumonia, bilateral — Duration

Due to arteriosclerosis CVD. — 10 yrs

Due to arteriosclerosis, general. — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Richard Compton

Address Hospital for Women Date signed 7/21/45 M.D.

VS 150

X

G30914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

Registered No. G30914

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2417 W. North Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2417 W. North Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE M. STEARNS

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: *Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Howard C. Stearns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1869

8. AGE: Years 75 | Months 11 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Louis W. Cadwallader

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Mary E. Chalmers

15. Birthplace Balto., Md.

16 (a) Informant Mr. Howard C. Stearns

(b) Address 2417 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 JUL 22 1945 (Date received by registrar) (by) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 7:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1945 to July 19 1945 and that I last saw h[illegible] alive on July 19 1945

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Degeneration	3
Due to Myocardial Failure	4/11/45
Due to Generalized Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Philip F. Larner

Address 2401 W. North Ave. Date signed 7/20/45

VS 150

X

G30915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80 B

Registered No. G30915

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Riggs Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeanne Stedstill (Also known as Jeannie M Heath)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1942

8. AGE: Years 2 yrs | Months 7 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER 12. Name Woodrow Evans

13. Birthplace Balto, Md

MOTHER 14. Maiden Name Tommie Stedstill

15. Birthplace Fla.

16 (a) Informant Tommie Steedstill

(b) Address 1527 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. Co. Md.

18 (a) Funeral director Chas H. Alexander

(b) Address 927 N. Mount St.

19 (a) 7/22/1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 4:44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945 to July 20 1945, and that I last saw h[illegible] alive on July 20 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Toxic Encephalitis.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion E. Drake M. D.

Address Univ. Hosp Date signed 7-31-45

VS 180

G30916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 733 2nd St. N.E. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME: Arthur Blader

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1905

8. AGE: Years	Months	Days	If less than one day
39	7	24	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER
12. Name Joseph Blader
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Seek
15. Birthplace Maryland

16 (a) Informant Hospital Records.
(b) Address

17 (a) Removal (b) Date thereof 7-21-45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Hyattsville
Location Maryland

18 (a) Funeral director Francis Walsh & Son
(b) Address Hyattsville, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 20 1945, and that I last saw him alive on July 20 1945.

Immediate cause of death	Duration
Vascular Collapse	1 hr
Due to Diabetic Acidosi and Uraemia	11 hr
Due to Diabetes & Chonic Nephritis.	12 yrs.
Other Conditions Multiple Carbuncles, Glaucoma, Cardiac decompensation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent de P. Fitzpatrick Jr. M. D.
Address Mercy Hospital Date signed 7/20/45

AUG 2 1945

X

G30917

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 467

G30917
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE C. LOWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie R.

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 10 - 6 - 63

8. AGE: Years 81 | Months 9 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick County
(Town, county, and state)

10. Usual Occupation Retired Miller

11. Industry or business

FATHER 12. Name JOHN D. LOWMAN

13. Birthplace Maryland

MOTHER 14. Maiden Name Sidney Gosnell

15. Birthplace Maryland

16 (a) Informant John R. Lowman

(b) Address Mt. Airy, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)

(c) Cemetery or crematory Prospect
Location Near Mt Airy Frederick Co Md

18 (a) Funeral director C. M. Wall

(b) Address Winfield, Md.

19 (a) JUL 22 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 8 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 7-21 1945 and that I last saw him alive on July 21 1945

Immediate cause of death	Duration
Cardiac & Respiratory failure	
Due to Ch. myocarditis & arteriosclerosis	
Due to	
Other Conditions Ch. nephritis	

Post operative - abdl - primary Repair
(Include pregnancy within 3 months of death)
Date of operation July 19th 1945
Major findings of operation: Adenocarcinoma of rectum
of autopsy: Ch. heart dis & Pulmon. Con.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene H. Conner M. D.
Address University Hosp. Date signed 7-21-45

X

G30918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30918 Registered No. 62031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo, 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Carrabelle (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charlie Eugene Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Watkins
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	7	hr. min.

9. Birthplace Bainbridge, Georgia (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Andrew Jackson Campbell
13. Birthplace Georgia

MOTHER
14. Maiden Name Eugenia Swanson
15. Birthplace Georgia

16 (a) Informant Records - U. S. Marine Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)
(c) Cemetery or crematory
Location Apalachicola Fla

18 (a) Funeral director A. Lee Oder
(b) Address 644 York Rd

19 (a) 1945 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 6:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945, to July 20 1945, and that I last saw him alive on July 20 1945.

Immediate cause of death Carcinoma of lung with metastasis to spine — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/21/45

G30919 T679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30919 Registered No. 46E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway & Monument St.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 mo.
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County: Balto
(c) City or town: Eccleston
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Edwin G. Baetjer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 25, 1868

8. AGE: Years	Months	Days	If less than one day
77 76	--	25	hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Lawyer

11. Industry or business

FATHER
12. Name: John G. Baetjer
13. Birthplace: Md

MOTHER
14. Maiden Name: Mary Koppelman
15. Birthplace: Md

16 (a) Informant: records
(b) Address: Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Greenmount Ave. & Oliver St.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 JUL 22 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1945, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4- 1945 to 7-20- 1945 and that I last saw h[illegible] alive on 7-20- 1945.

Immediate cause of death: Cachexia, anemia, prostration — Duration: [illegible]
Due to: Ca of Sigmoid metastasized — Duration: 5 yrs
Due to: — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lawrence Packer M.D.
Address: Johns Hopkins Hosp Date signed 7/20

VS 150

G30920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

G30920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3/3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Sequoia Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sol H. Abrams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Frances Abrams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Owner

11. Industry or business Spring Mfg. Co.

FATHER
12. Name Lewis Abrahs
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah (Unknown)
15. Birthplace Russia

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jack Revis Inc
(b) Address 1439 E. Balto. St.

19 (a) (Signature of Registrar) Huntington Williams M.D.

JUL 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/45 19 to 7/20 1945, and that I last saw him alive on 7/20 1945.

Immediate cause of death Extension of carcinomatous growth — Duration

Due to Carcinoma of Larynx

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/19/45

Major findings of operation: Air passage blocked. Tracheotomy necessary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph E. Read M. D.
Address Mercy Hospital Date signed 7/21/45

X

G30921 55

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G30921 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto — (If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 Narcissus Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steven W. Schreiber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-45

8. AGE: Years [redacted] | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Md — (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Aaron L. Schreiber

13. Birthplace Md

MOTHER 14. Maiden Name Henrietta Feldman

15. Birthplace Md —

16 (a) Informant Records —

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-45 (month) (day) (year)

(c) Cemetery or crematory Pikesville Hebrew Cemetery

Location Pikesville Baltimore Co.

18 (a) Funeral director Jack Levy

(b) Address 1439 E. Baltimore St.

19 (a) Date received by Local Registrar JUL 22 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to July 20 1945 and that I last saw him alive on July 20 1945

Immediate cause of death: Paralytic Ileus — Duration: 1 Day

Due to: Diarrhea — 1 wk 2 Days

Due to: Septicemia

Other Conditions: Osteomyelitis — 6 Wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena P. Hall Asst Res

Address Hopkins Hospital Date signed 7-21-45 M. D.

G30922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G30922 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1504 E.Oliver Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1504 E.Oliver St
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Stromer

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-4419

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marguerite Berger

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 8, 1883

8. AGE: Years 62 | Months 3 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Gas-fitter

11. Industry or business Gas & Electric Co

FATHER
12. Name Henry Stromer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Franz
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marguerite Stromer

(b) Address 1504 E.Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) 22 1945 ... by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Jul 19 1945.
and that I last saw h-- alive on Jul 18th 45.

Immediate cause of death
Acute Coronary Insufficiency
Secondary Renal Disease

Duration

Due to

Due to

Other Conditions Bronchial Asthma 4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Allen E. Sikorsky M.D.

Address 1939 Fe Ellen St Date signed 7/20/45

1 copy
630923

Dr Klimer ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30923
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2300 E Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. Madison St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Sevcik

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph Sevcik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE: Years 68 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Bohemia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Cacky
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Seevency
15. Birthplace Bohemia

16 (a) Informant Anna - Kerbe
(b) Address 2715 Kildare Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Grachan Son
(b) Address 909 N. Chester St

19 (a) (Signature of) Registrar
(Date rec'd by registrar)

JUL 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 6.A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944, to July 19 1945, and that I last saw her alive on July 19 1945.

Immediate cause of death: Coronary artery disease
Myocarditis
Duration: 7 mo.

Due to Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klimer M. D.
Address 2529 E. Monument Date signed 7/20/45

G30924
CWK-94502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30924
Registered No. 5112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 E. Preston Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Whitty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Katharine Whitty (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-1870

8. AGE: Years	Months	Days	If less than one day
75	1	29	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Whitty
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia White
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23/45 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director Edward J. Gutelius Son
(b) Address 924 Pennsylvania Ave, Baltimore, Md

19 (a) JUL 22 1945 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 19 1945, and that I last saw h. im alive on July 19 1945.

Immediate cause of death	Duration
Metastatic Carcinomatosis	5 yrs
Due to Carcinoma of prostate.	over 5 yrs.
Due to	
Other Conditions Hypertensive Cardiovascular disease (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto City Hosps Date signed 7-20-45

X

G30925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30925 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 928 E. Eager St.

(c) Hospital or institution: At Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 928 E. Eager St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James F. George

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ida V. Simmons George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1874

8. AGE: Years	Months	Days	If less than one day
71	0	12	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas George

13. Birthplace Va

MOTHER 14. Maiden Name Mary Ella Headly

15. Birthplace Va

16 (a) Informant Mrs Ida George

(b) Address 928 E. Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial Park

Location Taylor Ave W. of Harford Rd

18 (a) Funeral director Palmer W. Corkling's Son

(b) Address 924 E. Eager St Huntington Williams, Mgr

19 (a) (Date received by registrar) (b) Registrar

JUL 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21. 1945 at 3.0 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 to July 18 1945 and that I last saw h[im] alive on July 18 19 45

Immediate cause of death Acute Coronary Thrombosis

Due to Ch Myocarditis

Due to Ch Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. A. Hornstein M. D.

Address 733 Regester St Date signed 7/22/45

G30926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G30926 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3624 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) mo 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3624 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME George W Schilling

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Rita M Schilling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17-1872

8. AGE: Years	Months	Days	If less than one day
72	8	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business Self

FATHER
12. Name George Schilling
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fetterman
15. Birthplace Baltimore Md.

16 (a) Informant Rita M Schilling
(b) Address 3624 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Charles P Towell
(b) Address 2927 Edmondson Ave

19 (a) Date received July 22 1945 (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18th 1945, at 10:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1941, to July 18 1945 and that I last saw h[illegible] alive on July 18 1945.

Immediate cause of death	Duration
a Cute Cerebral Hemorrhage	
Due to ch arterio sclerosis	
Due to	
Other Conditions ch hypertension	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M.D.
Address 733 Augusta Rd Date signed 7/24/45

VS 150

G30927 Downin

BALTIMORE CITY HEALTH DEPARTMENT G30927 Registered No.

CERTIFICATE OF DEATH 13a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3610 Elm Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 16
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Virginia Downin DOWNIN

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	widowed

6 (b) Name of husband ~~or wife~~ Charles Willard Downin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1863

8. AGE: Years	Months	Days	If less than one day
82	2	17	hr. min.

9. Birthplace Hagerstown Md.
(Town, county, and state)
10. Usual Occupation house work.
11. Industry or business

FATHER
12. Name Samuel Fegley.
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Mary Catherine Howard.
15. Birthplace Hagerstown Md

16 (a) Informant Deadora Preston
(b) Address 304 Gwynn Ave.

17 (a) Burial (b) Date thereof July 23 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Ridge
Location Pikesville Md.

18 (a) Funeral director Clarence Hoffman
(b) Address 3616-18 Wheatsheaf Ave

19 (a) 7-23-45 (b) Herrington-Williamson Mort
(Date rec'd by registrar) (Registrar)

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11- 1944, to 7-20- 1945, and that I last saw her alive on 7-18- 1945

Immediate cause of death	Duration
Coronary Thrombosis	8 days
Due to Organic Heart Disease	Unknown
Due to	
Other Conditions Chronic Interstitial Nephritis - Unknown	
Hypertension.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 7-20-45

95c

G30928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G30928 Registered No. (Fax)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Forden
(c) Hospital or institution: Maryland General 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3523 Clipper Road "11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence M. Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-4566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Bertie L. Watkins
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1898

8. AGE: Years	Months	Days	If less than one day
47	4	28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation machinist
11. Industry or business Balmar Corp.

FATHER
12. Name Howard Watkins
13. Birthplace Va Maryland

MOTHER
14. Maiden Name Annie McDonald
15. Birthplace Md.

16 (a) Informant Bertie L. Watkins.
(b) Address 3523 Clipper Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 1945 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden.

18 (a) Funeral director Schumacher & Donaran
(b) Address 2615-17 Eastern Ave

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1945 at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1945 to 7/21 1945 and that I last saw h alive on 7/20 1945

Immediate cause of death Acute Hepatitis & Nephritis — Duration 20 days

Due to Acute Cholecystitis with Cholelithiasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martha E. Strahl M. D.
Address Md. Gen'l Hospital Date signed 7/24/45

VS 150

G30929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30929 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2909 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2909 Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Wolff.

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-05-3148

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1878

8. AGE: Years	Months	Days	If less than one day
66	8	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Insulator.

11. Industry or business B. & O. R. R.

FATHER
12. Name John M. Wolff.
13. Birthplace Germany.

MOTHER
14. Maiden Name Fredricka Hess.
15. Birthplace Md.

16 (a) Informant Margaret A. Wolff.
(b) Address 2909 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23 1945 (mo.) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Eshenauer & Donaghy
(b) Address 1615-17 Eastern Ave.

19 (a) Date received by registrar Huntington Wilkinson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 1230 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to July 20 1945, and that I last saw h. alive on July 19 1945.

Immediate cause of death Coronary thrombosis. — Duration 1 hour

Due to Arteriosclerotic type of heart disease with chronic myocarditis — Duration 2 years

Due to congestive failure — Duration 2 years

Due to hypertension. — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave Date signed July 21/45

X

G30930 BALTIMORE CITY HEALTH DEPARTMENT G30930

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Hammonds Lane (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Melvin Douglas Dornon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 7, 1945

8. AGE: Years	Months	Days	If less than one day
—	2½	19	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul Dornon
13. Birthplace Keyser, W. Va.

MOTHER
14. Maiden Name Olive Springer
15. Birthplace Weston, Port Md.

16 (a) Informant Olive Dornon
(b) Address Hammond Lane (Brooklyn)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Jos Patches Highway

18 (a) Funeral director Milton Schellinger
(b) Address 3914 S. Hanover St.

19 (a) JUL 22 1945 (Date received by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1945, at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1945, to 7/21 1945, and that I last saw h/M. alive on 7/21 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Pertussis	37 days
Due to H. Pertussis	
Other Conditions Bronchopneumonia	9 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Swink, M. D.
Address Sydenham Hosp Date signed 7/21/45

VS 8

G30931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G30931 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3646 S Hanover Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3646 SHanover Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest A Kruse

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-3965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Eliza R Kruse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24th 1864

8. AGE: Years	Months	Days	If less than one day
81	1	27	hr. min.

9. Birthplace Baltimore Md
10. Usual Occupation Operator of Air Compresser
11. Industry or business Arudel Corp.

FATHER
12. Name Frederick Kruse
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John A Kruse
(b) Address 3646 S Hanover Street 25

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-45 (month) (day) (year)
(c) Cemetery or Cedar Hill Cem
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schulting
(b) Address 3914 S Hanover Street 25

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20th 1945 at 6PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 20 1945.
and that I last saw him alive on 7/18/ 1945.

Immediate cause of death

Cerebral sclerosis

Due to (or as a consequence of) with Cerebral thrombosis

Due to

Other Conditions arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rule M. D.
Address 203 Dalopga Date signed

VS 150

G30932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G30932 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3216 Woodland ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Woodland ave (If rural give location)
3216
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Moeran

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Geo. H. Moeran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29. 1882

8. AGE: Years	Months	Days	If less than one day
62	9	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jane Hutchins
15. Birthplace Maryland

16 (a) Informant Mrs. Geo. H. Moeran
(b) Address 3211 Woodland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto. Md.

18 (a) Funeral director Jerome C. Byrer
(b) Address 1600 W. North Ave.

19 (a) 7-22-45 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 3-20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to July 20 1945.
and that I last saw h.. alive on July 20 1945

Immediate cause of death Pulmonary oedema

Due to Chron. Mutral Endocarditis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 dys.
unknown
unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Cullen M. D.
Address 4426 Park Hts Ave Date signed 7-21-45

G30933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G30933 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 N. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 N. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wilhelmena Brown Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1907

8. AGE: Years 38 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, or state)

10. Usual Occupation Beautician

11. Industry or business

FATHER 12. Name Harry Anderson

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Wilhelmena Griffin

15. Birthplace Balto. Md.

16 (a) Informant Wilhelmena Anderson

(b) Address 1407 N. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Pk.

Location Balto. Co. Md.

18 (a) Funeral director Geo. W. Dallas

(b) Address 1631 Pa. Ave.

19 (a) [illegible] (Date rec'd by registrar) JUL 22 1945

(b) [illegible] for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 4:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20/45 to 7/19/45, and that I last saw he alive on 7/14/1945.

Immediate cause of death Int. Acute Bacterial Endocarditis

Due to Local infection

Due to Hemiplegia of Left side

Other Conditions Pain

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 days, 2 days, 2 mos.

PHYSICIAN Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify which place)

(e) Means of injury

23. Signature J. F. Dankadale M. D.

Address 524 N. Carey St. Date signed 7/21/45

VS 150

G30934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G30934 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 N. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 N. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1925

8. AGE: Years 19 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name Robert Lewis

13. Birthplace Lancaster Co. Va

MOTHER 14. Maiden Name Anna Carter

15. Birthplace Lancaster Co. Va

16 (a) Informant Robert Lewis

(b) Address 1314 N. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lee A. Stafford

(b) Address 631 Druid Hill Ave.

JUL 22 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19- 1945 at 11:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10, 1945 to July 19, 1945 and that I last saw him alive on July 19, 1945.

Immediate cause of death Sarcoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Campbell M. D.

Address 718 Dolphin St. Date signed 7-21-45

17

VS 150

G30935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G30935
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 N. Patterson Pk. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 531 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie D. Caldwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1883

8. AGE: Years 55 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas H. Jones
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Charlotte Dougherty
15. Birthplace Baltimore, Md.

16 (a) Informant Ella Bivens
(b) Address 531 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 JUL 22 1945 (Date rec'd by registrar) Per Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19-1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1943, to 7-19 1945; and that I last saw her alive on 7-19 1945.

	Duration
Immediate cause of death	
Cardio-Vascular,	
Due to Renal Disease.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Sutton M.D.
Address 2033 Druid Hill Ave. Date signed 7/21/45

VS 150

G30936
CMK-94717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
124 B

G30936
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7805 Meath Road-Dundalk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Harry Sadler

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Sadler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1898

8. AGE: Years	Months	Days	If less than one day
46	7	12	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Murray Sadler
13. Birthplace Pa.

MOTHER
14. Maiden Name Marie Little
15. Birthplace Pa.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 24 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location New York, Pa.

18 (a) Funeral director Mr. G. Feaser
(b) Address Hanover Pa.

19 (a) Filed by registrar Huntington Williams, M.D. Registrar

JUL 22 1945
VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH July 21 19 45, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 19 45 to July 21 19 45, and that I last saw h 13 alive on July 21 1945.

Immediate cause of death	Duration
Oesophageal Hemorrhage	7 days
Due to Esophageal Varices	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-16-45
Major findings of operation: Neg except for early cirrhotic liver
of autop Esophageal Varices Oesophagus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F.H. Cutler M.D.
Address 4940 Eastern Ave Date signed 7-22-45

F.H. CUTLER, M.D

G30937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G30937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Millington Hoe
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Middleton Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary L Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-2574

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 1896

8. AGE: Years	Months	Days	If less than one day
49	6	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Emerson Baking Co.

FATHER
12. Name Patrick Lee
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McDermott
15. Birthplace Maryland

16 (a) Informant Son: Arthur
(b) Address 308 Mt Albert Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Frederick Rd.

18 (a) Funeral director John J Gannon & Son
(b) Address 1012 Eutaw Pl

23 1945 by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1945 to 7/20 1945 and that I last saw h[illegible] alive on 7/20 1945.

Immediate cause of death: Cerebral Embolism — Duration

Due to: Chronic arteriosclerosis. Cardiac vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Russell Jr M.D.

Address St. Agnes Hosp Date signed 7/20/45

VS 180

G30938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30938 Registered No. 124 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Maryland Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifelong

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Owings Mills, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Mrs. Annie M. Peeling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	

6 (b) Name of husband or wife Charles A. Peeling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1873

8. AGE: Years	Months	Days	If less than one day
72	4		hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Home Maker

11. Industry or business

FATHER
12. Name Isaac Van Horn
13. Birthplace Md.

MOTHER
14. Maiden Name — Chalk
15. Birthplace Md.

16 (a) Informant Chas A Peeling
(b) Address Owings Mills

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-45
(month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem
Location Balto Co.

18 (a) Funeral director J. F. Elms' Sons
(b) Westminster for Williams, Md

23 1945 Reisterstown Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1945 to 7- 19, and that I last saw h[illegible] alive on 7-21 1945.

Immediate cause of death	Duration
Interval Hemorrhage	
Due to Cirrhosis of liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. H. Bryan, Jr.

Address Maryland Gen Hosp Date signed 7-21-45 M. D.

VS 150

G30939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural near Parkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. West of Parkton.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Heiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	20	hr. min.

9. Birthplace York Co., Pa.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name Penfield Heiss
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Miller
15. Birthplace Pa.

16 (a) Informant Raymond Heiss
(b) Address Parkton, Md. R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Middletown Cem
Location Freeland, Md. R.D.

18 (a) Funeral director Jacob Hartenstein
(b) Address Westminster, Md. R.D. Freedom, Pa.

19 (a) JUL 23 1945 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1945 to 7-22 1945, and that I last saw him alive on 7-22 1945.

Immediate cause of death	Duration
Pulmonary infarct	
Due to appendicitis.	
Due to following appendectomy	
Other Conditions Arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation 7-18 45
Major findings of operation: Gangrenous ruptured appendix.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R. Callender M. D.
Address University Hospital Date signed 7-23-45

VS 150

G30940

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 517

Registered No. G30940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Strawberry Alley.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME J. Herbert (Cissy) Christy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	~~Single~~ Widowed

6 (b) Name of husband or wife Frances Christy
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace ? Maryland
(Town, county, and state)
10. Usual Occupation Farm Laborer
11. Industry or business

FATHER
12. Name ~~John Christy~~ Christy
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Strawberry
15. Birthplace Maryland

16 (a) Informant Md. University Hospital
(b) Address Balto. Md.

17 (a) Burial (b) Date thereof July 25 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Swan Creek
Location Harford Co. Md.

18 (a) Funeral director R. Madison Mitchell
(b) Address Havre de Grace, Md.

19 (a) (b) Huntington Williams, M.D.

JUL 23 1945
State Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945, to July 21 1945, and that I last saw him alive on July 21 1945.

	Duration
Immediate cause of death Bronchopneumonia,	Unknown
Due to Carcinomatosis of the Peritoneum with ascites and generalized	Unknown
Due to Metastases	
Other Conditions Hemorrhoids. Dental Caries. Pyorrhea.	Unknown

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Carl Eisenhower M.D.
Address Univ. Hosp. Date signed 7-24-45

VS 150

X

G30941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30941

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 MO.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town TEXAS
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adelia Ruth Chaffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Benjamin Chaffman
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1898

8. AGE: Years	Months	Days	If less than one day
47	5	22	hr. min.

9. Birthplace Virginia (Culpepper)
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Montgomery Monck
13. Birthplace Va.

MOTHER
14. Maiden Name Hattie Manning
15. Birthplace Va.

16 (a) Informant Benjamin Chaffman
(b) Address Texas Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 26 45 (month) (day) (year)
(c) Cemetery or crematory Poplar Methodist
Location Cockeysville Md.

18 (a) Funeral director Loudon & Brooks
(b) Address Sparks Md.

19 (a) Date received JUL 23 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to 19, and that I last saw h.E.R. alive on July 22 1945.

Immediate cause of death Ventricular Tachycardia

Due to Hypertensive Cardiovascular Renal Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry W. Camp M. D.
Address Mercy Hosp. Date signed 7/24/45

VS 150

G30942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

Registered No. G30942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GIVEN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Aliceanna St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Aliceanna st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Ratajczak

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-1954

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1893

8. AGE: Years	Months	Days	If less than one day
52	5		hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business J. Lauzell Bros Inc

FATHER
12. Name Michael Ratajczak
13. Birthplace Poland

MOTHER
14. Maiden Name Viola Bontkowski
15. Birthplace Poland

16 (a) Informant Mrs. Viola Ratajczak
(b) Address 1908 Aliceanna St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linn street, Huntingtown Williams, Md.

JUL 23 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21- 1945 at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Gutzeit M.D. Medical Examiner.
Date signed July 24, 1945

VS 151

G30943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G30943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Maryland General Hospital 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 909 St. Lumbar Court (If rural give location)
(e) Citizen of foreign country? Baltimore (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Meekins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Carrie Meekins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1913

8. AGE: Years	Months	Days	If less than one day
32	-	11	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Phil Meekins
13. Birthplace N. C.

MOTHER
14. Maiden Name Josephine A. Cook
15. Birthplace N. C.

16 (a) Informant Victoria Jones
(b) Address 1124 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory Hamlet N. C.
Location N. C.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 JUL 23 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945; at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ~~or~~ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of Aorta

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D. (Medical Examiner.)
Date signed July 24, 1945.

VS 151

G30944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G30944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Orford ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Thomas Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-1089

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Laura May Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1902

8. AGE: Years	Months	Days	If less than one day
43	1	12	hr. min.

9. Birthplace md
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name William H. Thomas
13. Birthplace md

MOTHER
14. Maiden Name Mary Powell
15. Birthplace md

16 (a) Informant Laura May Thomas
(b) Address 519 Orford ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location md

18 (a) Funeral director George B. Nelson
(b) Address 1303 Pennsylvania ST

19 (a) JUL 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 1:30 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frater M.D.
Medical Examiner.
Date signed July 22 1945

VS 151

G30945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Laurens St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Laurens St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nora B. Janey

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Handy Janey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/1906

8. AGE: Years 38 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Susie Penn
15. Birthplace Md

16 (a) Informant Handy Janey
(b) Address 1818 Laurens St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** July 24 45 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Pennsman St

19. (a) JUL 22 1945 (Date filed by City Registrar) **(b)** Huntington Mills, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 19 1945. and that I last saw h[illegible] alive on July 19 1945

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] White M. D.
Address 1543 Fremont Ave **Date signed** 7-30-45

VS 8

G30946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G30946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 140 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. York Road Lutherville (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward R Krauff

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Irma E. Krauff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1898

8. AGE: Years 46 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (town, county, and state)

10. Usual Occupation Storekeeper

11. Industry or business None

FATHER
12. Name Edward Krauff
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hubbard
15. Birthplace Ohio

16 (a) Informant Irma Krauff
(b) Address 5516 Belleau Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Tilson & Son Inc
(b) Address 1217 E. Fort Ave.

JUL 23 1945 (Date rec'd by Registrar)

(b) Huntingtown, Calvert Co., Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 6:53 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 3 1945 to July 21, 1945 and that I last saw him alive on July 21, 1945

	Duration
Immediate cause of death: Pulmonary edema	4 hrs
Due to: ? Hypoprothrombinemia associated with severe Liver damage	4 days
Due to: (Chronic Emphysema) Tuberculosis Cutaneous	1 yr
Other Conditions: Catarrhal Jaundice	15 yrs 9 days

(Include pregnancy within 3 months of death)

Date of operation 5 operations on record 1940

Major findings of operation: Chronic Emphysema & Bronchio-cutaneous Fistula

of autopsy: Catarrhal Jaundice; Chronic Emphysema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert D Daly M. D.
Address Church Home & Hosp. Date signed 7-22-45

G30947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. G30947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~505 E. 27th St.~~ 3 3rd & Calvert

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 & 6.

(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 505 E. 27th St.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME William E. Bryan

3 (b) If veteran, name war ? W

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mrs. W. E. Bryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	22	hr. min.

9. Birthplace Baltimore, Balto. County, Md. (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business

FATHER

12. Name Charles Bryan

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Emma Klutz

15. Birthplace Baltimore Md

16 (a) Informant Lucile Bryan

(b) Address 505 E 27th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director Tilhom Lod Inc

(b) Address 1217 E Cold St

19 (a) Date received by registrar JUL 23 1945 (b) Registrar's signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945, at 12:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1945 to 7-22 1945, and that I last saw him alive on 7-21 1945.

Immediate cause of death Respiratory failure

Due to Ca of lung- Metastasis to brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3-21-45

Major findings of operation: Inoperable Ca of lung, left

of autopsy:

Duration
4 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Crawford W. Kirkpatrick, M.D.

Address Union Memorial Hosp. Date signed 7-22-45

VS 150

X Kirkpatrick

G30948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G30948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1000 Caton Avenue

(c) Hospital or institution: Jenkins Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1841 W. Lombard St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John McColgan

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17-1861

8. AGE: Years	Months	Days	If less than one day
84	4	4	hr. min.

9. Birthplace Alberton, Howard Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael J. McColgan

13. Birthplace

MOTHER 14. Maiden Name Mary Ann McColgan

15. Birthplace

16 (a) Informant Marie G. Perkins

(b) Address 1841 W. Lombard Sty

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)

(c) Cemetery or crematory Druid Hill

Location Baltimore Md

18 (a) Funeral director Gallagher Funeral Home

(b) Address 1219 E. Pratt St

19 (a) JUL 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to July 21 1945 and that I last saw h[illegible] alive on July 20 1945

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Chronic ulcers Arteriosclerotic	
Due to Cardio Vascular disease	
Other Conditions Hypertrophic arthritis numerous falls because I was (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Clifford Pollitt M.D.

Address St. Agnes Hosp. Date signed 7/24/45

G30949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G30949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 William St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 William St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie May Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Timothy J.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 22, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Geo. W. Reed
13. Birthplace Maryland.

MOTHER
14. Maiden Name Ann J. Hunter
15. Birthplace Pennsylvania

16 (a) Informant Timothy J. Miller
(b) Address 1005 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Henry Inc
(b) Address 715 Light St Baltimore, Md

19 (a) (b) Registrar

JUL 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1945, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945, to July 19 1945, and that I last saw her alive on July 19 1945

Immediate cause of death Diabetes — Duration 6 mos.
Due to Coma — 1 day
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Wheeler M. D.
Address 1179 William N Date signed 7/24/45

X

G30950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G30950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Toone Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Toone Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May B. Lidard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Clarence R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James Goodwin
13. Birthplace Baltimore

MOTHER
14. Maiden Name Eliza Bamber
15. Birthplace Baltimore

16 (a) Informant Mrs. Merle Stephens
(b) Address 3400 Toone Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 JUL 23 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to July 20 1945, and that I last saw h[illegible] alive on July 20 1945.

Immediate cause of death Hypernephroma - left (renal) gland — Duration 1-2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George D. Lilly M. D.
Address 1718 Eutaw Pl. Date signed 7/24/45

VS 150

G3095492
33492

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48 B

Registered No. G30951

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Gwyns Falls Pkwy (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Goodman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-1881

8. AGE: Years	Months	Days	If less than one day
63	7	10	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Saleswomen
11. Industry or business

FATHER
12. Name Soloman Goodman
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Rider
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral dir. Harris Sonnebrun & Son
(b) Address 1902 Eutaw Place

19 (a) JUL 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945 at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23- 1946 to 7-22-1945 and that I last saw her alive on 7-22- 1945

Immediate cause of death
(a) Carcinoma of the uterus

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 5-19-45

Major findings of operation: Adeno-Carcinoma of uterus

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard F. Kieffer Jr. M. D.
Address Johns Hopkins Hosp. Date signed 7-23-45

VS 150

G30952 Hanover 5111 York Rd

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G30952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 725 Highwood Dr

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 725 Highwood Drive

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carrie May Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Robert H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	29	hr. min.

9. Birthplace Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Through

13. Birthplace Md

MOTHER 14. Maiden Name Gillingham

15. Birthplace ?

16 (a) Informant Mr. Robert H. Bowen Sr

(b) Address 725 Highwood Dr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location

18 (a) Funeral director J. J. Rauch

(b) Address 6345 Reisterstown Rd

19 (a) (Registrar) (b) Huntington Williams, M.D. (Deputy)

JUL 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1944 to July 21 1945 and that I last saw her alive on July 21 1945.

Immediate cause of death	Duration
Pneumonia (Hypostatic)	2 days
Due to Uremia	8 day
Due to Chronic Interstitial Nephritis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Carl H Bowen M.D.

Address 5111 York Rd Date signed July 23, 1945

G30953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G30953

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1653 Abbotson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 Abbotson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John (Huthman) Huthman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace —
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Joseph Huthman
13. Birthplace

MOTHER 14. Maiden Name Josephine Lyd
15. Birthplace

16 (a) Informant —
(b) Address —

17 (a) Burial (b) Date thereof 7-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location

18 (a) Funeral director L. J. Rauch
(b) Address 5405 Harford Rd

19 (a) JUL 23 1945 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945, at 9A. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions Mental Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8:30 A.m. at 7-21-45 M.
(b) Where did injury occur? 1653 Abbotson Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Shot himself with a 38 pistol
(e) Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 21, 1945.

VS 151

G30954 46-225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57

✓ G30954 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5713 Benkram Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Anderson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edward A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-21

8. AGE: Years 24 | Months 6 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife -

11. Industry or business

FATHER 12. Name Harry L Shupp.
13. Birthplace Pa

MOTHER 14. Maiden Name Lolly Golden -
15. Birthplace Pa

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director J J Rice & Co
(b) Address 5305 Harford Rd

19 (a) JUL 23 1945 (Date received, registered) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1945 to July 21 1945 and that I last saw [illegible] alive on July 21 1945

Immediate cause of death Pneumothorax Duration
Failure due to probable Brain Tumor.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7/19/45

Major findings of operation Incised and drainage Procedure

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lewis Hawkins Asst. Date signed 7/21/45
Address Johns Hopkins Hosp. Balto. Md. X

VS 150

G30955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G30955

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Calvert
(c) City or town Huntingtown P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice K. Scrivener

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mrs Lavinia Alban Scrivener
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1875

8. AGE: Years	Months	Days	If less than one day
69	8	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Charles W. Scrivener
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Alban Brown
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Keech
(b) Address 5305 Mayfield Rd

19 (a) JUL 23 1945 (b) Huntingtown Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 21 1945 and that I last saw him alive on July 21 1945.

Immediate cause of death Generalized peritonitis, Bronchopneumonia — Duration

Due to 19 days post op. following resection of colon for cancer.

Due to

Other Conditions Adenocarcinoma of Sigmoid colon
(Include pregnancy within 3 months of death)

Date of operation July 12, 1945

Major findings of operation: Adenocarcinoma of sigmoid colon.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Lippincott Jr. M. D.
Address Union Memorial Date signed 7/21/45

VS 150

G30956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

90 13

Registered No. G30956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Dundalk 22 (Balto.)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Virginia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine LeBrun LEBRUN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Wm LeBrun

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 27 1897

8. AGE: Years	Months	Days	If less than one day
47	8	26	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business Home

FATHER
12. Name Wm. Bohle
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Bey
15. Birthplace Germany

16 (a) Informant Hosp. record
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 25/45 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Tully & Foster
(b) Address 403 S. WOLFE ST.

19 (a) JUL 23 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1945 to 7-22 1945 and that I last saw h[illegible] alive on 7-22 1945

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Pericardial effusion & Myocardial failure

Due to ?

Other Conditions Marked obesity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home Date signed 7-23-45

G30957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. G30957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Brantley ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Brantley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha E. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	W.

6 (b) Name of husband or wife Henry C. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1885

8. AGE: Years	Months	Days	If less than one day
60	4	4	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business At Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Walter Brown
(b) Address 1007 Brantley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley ave

19 (a) Date received JUL 28 1945 (b) Huntington Williams, M.D.

VS 150

7/21/45 1245 PM

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21- 1945, 1245 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1945 to 7/21 1945
and that I last saw h alive on 7/20 1945.

Immediate cause of death Cardio-Renal — Duration 5 hrs

Due to — Duration 8 days

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hoffecker M. D.
Address 1725 Pine St Date signed 7/21/45

G30958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G30958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1718 N. Calvert St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Gustav K. L. Walters

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1873

8. AGE: Years	Months	Days	If less than one day
71	7	7	hr. min.

9. Birthplace New Jersey

(Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER

12. Name Friedrich Karl Walters

13. Birthplace Germany

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Louise L. Brent

(b) Address 3811 Forrester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director L. J. Rush

(b) Address 5305 Reisterstown Rd

19 (a) (Registrar) (b) Huntington Williamsport, Md.

JUL 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to July 22 1945, and that I last saw him alive on July 22 1945

Immediate cause of death Resp. failure

Due to Cerebral hemorrhage

Due to Arteriosclerotic C. V. D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. F. Roltes M. D.

Address Date signed 7/22/45

X

630959

JO 451979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 630959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yrs. 6mos. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Junius Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Ernie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
51 ?	?	?	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Alexander
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sally Smith
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Norfolk Va
Location

18 (a) Funeral director Mrs Katye R Williams
(b) Address 3221 Schroeder St

19 JUL 23 1945 (b) Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16, 1940, to July 19, 1945, and that I last saw h im alive on July 19, 1945.

	Duration
Immediate cause of death: Cerebral vascular occlusion	
Due to: Generalized arteriosclerosis	20 yrs
Due to:	
Other Conditions: Arteriosclerotic gangrene - Rt. foot. (Include pregnancy within 3 months of death)	

Date of operation 7-3-45
Major findings of operation: Arteriosclerotic gangrene Rt foot
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill MD M. D.
Address Balto City Hospitals Date signed 7-21-45

G30960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30960

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 Caswell St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Caswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Gertrude Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/1868

8. AGE: Years 76 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John C. Armstrong
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Nellie Kelly
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Anna Hamberl
(b) Address 1913 E. 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or Parkwood
Location Parkville, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St. #2

19 (a) JUL 23 1945 (Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945, at 10 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atherosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gaston M.D. Medical Examiner.
Date signed July 23 1945

VS 151

2

G30961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G30961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4626 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 T. + 6
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4625 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Sonneborn
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 75 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Kaufman
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Leon Sonneborn
(b) Address 4625 Park Heights Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto St

19 (a) JUL 23 1945 Hunting Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1945 to 7-22 1945 and that I last saw h alive on 19

Immediate cause of death Coronary Attack — Duration

Due to Kidney Degeneration

Due to Myocarditis

Other Conditions Cataract

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7/27/45

Approved: Robert A. Gaston M.D.

VS 150

G30962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

Registered No. G30962

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1901 McKean Ave.

(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1901 McKean Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie C. Doretell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	25	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Joseph Doretell

(b) Address 1901 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/45 (month) (day) (year)

(c) Cemetery or crematory St. Michaels

Location Ridge Md.

18 (a) Funeral director Martin Bahr & Sons

(b) Address 1827 N. North Ave

19 (a) JUL 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1945 to July 20 1945, and that I last saw h[illegible] alive on July 20 1945.

Immediate cause of death Carcinoma of Stomach

Due to Metastatic Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel D. Wolfe M. D.

Address 1331 E. North Ave Date signed 7-24-45

VS 150

G30963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30963 (Registered No.) 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 N Strickland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N Strickland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Carrie A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 - 1885

8. AGE: Years	Months	Days	If less than one day
60	2	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Meat Inspector
11. Industry or business Baltimore City Health Dept.

FATHER
12. Name Charles Smith
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name —
15. Birthplace Baltimore, Md

16 (a) Informant Carrie A. Smith
(b) Address 320 N Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. B. Wimsatt & Son
Address 1856 W. Baltimore St

19 (a) JUL 29 1945 (Date rec'd by registrar) (b) Huntington for Nathaniel Wolfe, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1935 to July 26 1945 and that I last saw him alive on July 26 1945

Immediate cause of death Coronary Occlusion — Duration 3 days

Due to Arteriosclerosis

Due to

Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Damian P. Alagia, M.D.
Address 330 Cathedral St Date signed 7/27/45

VS 150

Approved: Robert Lee Fratzen M.D.

G30964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Goodwin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Goodwin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Shanahan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	White	Married

6 (b) Name of husband or wife Frank M Shanahan
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 9 1897

8. AGE: Years	Months	Days	If less than one day
48	-	14	hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ,

MOTHER
14. Maiden Name ,
15. Birthplace ,

16 (a) Informant Frank M Shanahan
(b) Address 1200 Goodwin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Tillman Lodge Co
(b) Address 1217 E Pratt St

19 (a) Filed 7-23-1945 (State registrar) (b) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23, 1945 at 1a.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22, 1945 to 7-22 1945, and that I last saw her alive on 7-22, 1945.

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to cardio-renal-vascular disease with anasarca	indef.
Due to Chronic myocard. disease	"
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron V. Boyko, M. D.
Address 1626 N. Caroline St Date signed 7-22-1945

VS 150

G30965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G30965

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Smith County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT S. VENEABLE

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1870

8. AGE: Years 75 | Months | Days | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Robert Carter
(b) Address 826 E. Baltimore St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Princeton
Location W. Va.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) JUL 23 1945 Registrar [illegible] Huntington for Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 9:45 P. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-22-45 at 9:30 P. M. 5/1
(b) Where did injury occur? 826 Balto. Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home (Relatives) While at work? No
(d) Means of injury Fell from 3rd floor window

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed July 23 1945

VS 151

C30966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C30966

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Floyd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Welfare Department
(b) Address 329 St. Paul Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md.

JUL 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945 at 1:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gerstley M.D. Medical Examiner.
Date signed July 21, 1945.

G30967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G30967

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Elsinor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Elsinor Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Ostheim

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
----	none	Male	White	Widower

6 (b) Name of husband or wife Amelia K. Ostheim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1858

8. AGE: Years	Months	Days	If less than one day
87	0	2	hr. min.

9. Birthplace Fallston, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Ostheim
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Horr
15. Birthplace Germany

16 (a) Informant Miss Oleita Ostheim
(b) Address 2208 Elsinor Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

JUL 23 1945 (Date received by registrar) Huntington Williamsville, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945 at 3.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 7 1945 to July 21 1945 and that I last saw him alive on July 21 1945

Immediate cause of death	Duration
Arteriosclerosis	10 yr
Chronic Myocarditis	1 Yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature
Address 3207 W. North Ave. Date signed 7/27/45 M. D.

VS 150

G30968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G30968

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Jesilionis.
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-03-9419

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	M

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 13th 1900

8. AGE: Years	Months	Days	If less than one day
44	11	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Truck driver
11. Industry or business

FATHER
12. Name Charles Jesilionis.
13. Birthplace Md.

MOTHER
14. Maiden Name Anna G. Pulske
15. Birthplace Md.

16 (a) Informant Wife — Anna
(b) Address 819 Hollander St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director John A. Dreblianeck Jr.
(b) Address 1423 E. Pacca St.

JUL 23 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 7/21 1945.
and that I last saw h. alive on 7/21 19 45 @ 12 30 PM

Immediate cause of death Uremia

Due to chronic glomerulo nephritis

Due to

Other Conditions hypertension

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Bobby L. James, M.D.
Address Franklin Square Hosp. Date signed 7/23/45

G30969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30969

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Lanvale Sts
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 W. FRANKLIN ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND ANDREW KVECH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 19, 1932

8. AGE: Years	Months	Days	If less than one day
12	11	9	hr. min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)

10. Usual Occupation STUDENT

11. Industry or business

FATHER
12. Name HENRY (KVECH) KVECH
13. Birthplace BALT. Md. CZECHOSLOVAKIA

MOTHER
14. Maiden Name JEANETTE (GRUBICH)
15. Birthplace BALT. Md

16 (a) Informant MRS. HENRY (KVECH) KVECH
(b) Address 3403 W. FRANKLIN ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Brazenski
(b) Address 1930 Eastern Ave

(a) Washington Williams, M.D. Registrar

JUL 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1945 to July 20 1945 and that I last saw him alive on July 20 1945

Immediate cause of death	Duration
ACUTE LYMPHATIC LEUKEMIA	?
Due to —	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry W. Camp, M.D.
Address Mercy Hosp. Balt. Md. Date signed 7/20/45

VS 150

G30970 G30970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland East n City Jail.
(b) Street address 801 Burrin St
(c) Hospital or institution: East n City Jail Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Austin

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 23 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 23 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1945, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945, to July 9 1945, and that I last saw him alive on July 9 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	2 hrs
Due to Myocarditis	?
Due to Generalized Arteriosclerosis	?
Other Conditions Malnourished	(Days)

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Wade M. D.
Address East n City Jail Date signed

VS 180

F 2858

G30971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G30971

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC HENRY GRAHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lottie Lee Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	8	hr. min.

9. Birthplace Deltaville, Va.
(Town, county, and state)
10. Usual Occupation Watchman (Retired)
11. Industry or business Wilson Line

FATHER
12. Name J. K. Graham
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Deagle
15. Birthplace Va.

16 (a) Informant Mrs. Lottie L. Graham
(b) Address 1225 N. Bentalou St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Amburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 23 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1945, to July 22 1945, and that I last saw him alive on July 13 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Robertson M. D.
Address 422 Med. Arts Bldg. Date signed 7/23/45

VS 150

C30972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

C30972

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2735 W. North Ave.
(c) Hospital or institution: 1516
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA K. WEBER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Frank J. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	18	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: ---

FATHER
12. Name: George Krammer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia
15. Birthplace: Germany

16 (a) Informant: Frank J. Weber
(b) Address: 2735 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-1945 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Baltimore county

18 (a) Funeral director: Wm. J. Tickner & Sons.
(b) Address: North & Penna Aves.

23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945, at 4.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1945, to July 20 1945, and that I last saw her alive on July 20 1945.

Immediate cause of death	Duration
General Carcinomatosis	
Due to Cancer of breast.	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac C. Dickson, M. D.
Address 3155 W. North Ave Date signed 7/23/45

VS 180

X

G30973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G30973
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Hite

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1931

8. AGE: Years	Months	Days	If less than one day
14	5	4	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Walter S. Hite
13. Birthplace Ringgold, Va.

MOTHER
14. Maiden Name Emma Hubbard
15. Birthplace Va.

16 (a) Informant Mr. Walter S. Hite
(b) Address 604 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

JUL 23 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945 at 11 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-22-45 at 4/1 10 P.M.
(b) Where did injury occur? Guilford Ave. & Saratoga St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from moving of street car

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed July 23 1945

G30974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

G30974 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Mayer

3 (b) If veteran, name war — no
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	8	hr. min.

9. Birthplace Baltimore, md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business none

FATHER
12. Name Royce Mayer
13. Birthplace newberry, S. Carolina

MOTHER
14. Maiden Name Dola Sanders
15. Birthplace newberry, S. Carolina

16 (a) Informant Dola Sanders Mayer
(b) Address newberry, S. Carolina

17 (a) City Disposal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 23 1945 (Date rec'd by registrar) Christopher Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 6:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1945, to July 19, and that I last saw him alive on July 19 19 45 5 PM

Immediate cause of death	Duration
Terminal Bilateral Bronchopneumonia	1 day
Due to Intracranial Hemorrhage	8 days
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard T. Kurland M. D.
Address University Hospital Date signed 7/19/45

VS 180

2859

G30975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G30975 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr 13min
(e) Length of stay in Baltimore (yrs., mos., or days) 2hr 13min

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Hearts Lane
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Grant Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/19/45

8. AGE: Years	Months	Days	If less than one day
			2 hr. 13 min.

9. Birthplace Balto. md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Grant
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Evelyn Steward
15. Birthplace Baltimore md

16 (a) Informant Edelyn Grant
(b) Address 3012 Hearts Lane

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JUL 23 1945
18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 23 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-19-45 19 . at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19-45 19 45, to 7-19-45 19 45, and that I last saw him alive on 7-19-45 19 45.

Immediate cause of death	Duration
Congenital Atelectasis	
Due to	
Due to	
Other Conditions Prematurity (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marie Odom, M. D.
Address 312 E 23rd St Date signed 7-19-45

VS 150

F 2860 X

Dr. Collins 2321 Frederick Ave Tel 6112 Monday 6 PM
3001 Frederick Ave Tel PKwy 2201

G30976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G30976 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Milton st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Milton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia F. Bradley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband or wife Mortimer Bradley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9th about 1869

8. AGE Years	Months	Days	If less than one day
about 75	9	12	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Carrick
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Rose Macabee
15. Birthplace Howard Co. Md.

16 (a) Informant Marguerite Bender
(b) Address 2301 Frederick Ave

17 (a) Burial (b) Date thereof 7/24/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (Date received by registrar) (b) Huntington Williams M.D.
Filed JUL 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st 1945, at 5 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944, to July 21 1945, and that I last saw h er alive on July 7 1945.

Immediate cause of death	Duration
Arteria-sclerotic Heart	1 year
Due to Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Date signed 7-23-45

X

G30977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G30977 Registered No. 448

JO #92408

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 S. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Agnes Wieprecht or Agnes Szymborski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1902

8. AGE: Years	Months	Days	If less than one day
45	-5-	-3-	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Unemployed

11. Industry or business

FATHER
12. Name: Charles Wieprecht (d)
13. Birthplace: Md.

MOTHER
14. Maiden Name: Veronica Sito
15. Birthplace: Md.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof July 24 1945 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Dundalk, Md.

18 (a) Funeral director: Mendell & Klippel
(b) Address: 312 S. Highland Ave.

JUL 23 1945

(c) Filed by registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1945 19 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 5, 19 45 to July 19, 19 45, and that I last saw her alive on July 19, 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cardiac failure	
Due to Hodgkin's disease	
Other Conditions Marked anemia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jonathan Howland M. D.

Address: B. C. H. Date signed 7/24/45

X

G30978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G30978 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5147 Frederick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5147 Frederick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Pinkney Hardesty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 25, 1856

8. AGE: Years	Months	Days	If less than one day
89	5	24	hr. min.

9. Birthplace Bladensburg, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name James G. Hardesty
13. Birthplace Prince George County, Md.

MOTHER: 14. Maiden Name Emily Suit
15. Birthplace Bladensburg, Md.

16 (a) Informant Mrs. Wm. W. Merriken
(b) Address 5147 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director J. Miller Lamotte
(b) Address 4410 Liberty Heights Ave.

JUL 24 1945 (b)
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 19 1945, and that I last saw him alive on July 19 1945.

Immediate cause of death Carcinoma of Pancreas — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Eichman M D M.D.

Address 1921 E. North Ave. Date signed 7/20/45

G30979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G30979 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2025-W. Fayette St.
(b) Street address 3604 Mohawk Ave
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Mohawk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Henry Engel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna May Engel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation [redacted]
11. Industry or business Optometrist

FATHER
12. Name Henry Engel
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Hacker
15. Birthplace Germany

16 (a) Informant Dr. William Engel
(b) Address 3604 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4510 Liberty Heights Ave.

19 July 23 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22/1945, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15/1945 to 7/22/1945 and that I last saw him alive on 7/22/1945

Immediate cause of death Pulmonary Embolus — Duration
Due to Post Operative Perineal Prostatectomy
Due to
Other Conditions Cerebral Arteriosclerosis Aortic & Mitral Insufficiency
(Include pregnancy within 3 months of death)
Date of operation 7/20/45
Major findings of operation: Benign Hypertrophied Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Norton, M.D.
Address Bon Secours Hosp Date signed 7/23/45

VS 190

G30980 ✓ G30980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 62868

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 N. Rogers Avenue (If rural give location)
(e) Citizen of foreign country? Naturalized (Yes or No) If yes, name country

3 (a) FULL NAME Charles Martin Arzt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mete ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	9	5	hr. min.

9. Birthplace Michelstadt, Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ludwig Arzt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Crautz
15. Birthplace Germany

16 (a) Informant Records - U. S. Marine Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Balto Co.

18 (a) Funeral director Ehrlich Lanahan
(b) Address 1510 Liberty Heights Ave.

19 (a) (Date received by registrar) JUL 23 1945 (b) Huntington Williams, M.D. (Registrar)

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945, to July 22 1945, and that I last saw him alive on July 22 1945.

Immediate cause of death	Duration
Intestinal obstruction due to strangulation of intentine due to recurrent hernia	4 days
Due to	
Due to	
Other Conditions Arteriosclerosis, general; arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/23/45
Baltimore 11, Maryland.

G30981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

477

G30981 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3119 Glendale

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2414 E Fort Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Lula V Taylor

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1888

8. AGE: Years 57 Months 0 Days 14 If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Johnson

13. Birthplace Ga

MOTHER 14. Maiden Name Lucretia Pathe

15. Birthplace Ga

16 (a) Informant Thomas S Taylor

(b) Address 700 E 36th St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md

18 (a) Funeral director Tilton Funeral Home Inc

(b) Address 1214 E Fort Ave

19 Filed 9-24-1945 Huntington Williams MR (Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to July 22 1945, and that I last saw him alive on July 21 1945.

Immediate cause of death: Metastatic Carcinoma Left Lung — Duration April 1944

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury

23. Signature Morris B. Green M.D.

Address 3009 Gregory Ave Date signed 9/23/45

Baltimore 14 - Md. X

C30982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered C30982

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Markland.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Warden S.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Dec 9th, 1884

8. AGE: Years	Months	Days	If less than one day
60	7	12	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Henrietta James.
15. Birthplace Md.

16 (a) Informant Mr. Warden S. Markland
(b) Address 2709 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Ave.

18 (a) Funeral director John F. Dennis, Inc.
(b) Address 715 Light St.

19 (a) Date received July 24 1945 (b) Registrar's signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945 at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to July 21 1945, and that I last saw alive on 19

Immediate cause of death Carcinoma of Liver — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.
Address 2201 W. North Ave Date signed 7-23-45

VS 180

G30983 Ma 5901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G30983

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dun
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2225 Pennsylvania ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Bessie Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 1891

8. AGE: Years	Months	Days	If less than one day
54	4	29	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Carter
13. Birthplace Md

MOTHER
14. Maiden Name Susan Garner
15. Birthplace Md

16 (a) Informant Elizabeth Figueroa
(b) Address 2212 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto

18 (a) Funeral director Geo L Nelson
(b) Address 1303 Eutaw St

19 (a) JUL 24 1945 (Date received by Registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1945, at 10 45 PM

21. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Prostatic Hypertrophy c
Bilateral Hydronephrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature F C Pulaski M.D.
Medical Examiner.
Date signed 7-22-45

VS 151

G30984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G30984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Hosp.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Klavansky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife RACHAEL LENA-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name JUNDEL KLAVANSKY
13. Birthplace Russia

MOTHER
14. Maiden Name -
15. Birthplace Russia

16 (a) Informant LOUIS KLAVENS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-24-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location

18 (a) Funeral director JACK LEWIS, INC
(b) Address 1939 E. BALTO ST.

19 JUL 24 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-45 19 , at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 19 , 7/21 19 45
and that I last saw h[illegible] 7/21 19 45

Immediate cause of death Acute Bronchopneumonia — Duration

Due to Chr Myocarditis

Due to Generalized Sclerosis

Other Conditions -

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation: -

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hometani M. D.
Address 733 Augusta Ave Date signed 7/23/45

Huntington Williams, M.D.

VS 150

G30985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G30985

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 N. PULASKI ST
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 N. PULASKI ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RACHAEL TEBES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife SAMUEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOSEPH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DORA
15. Birthplace RUSSIA

16 (a) Informant MRS. SARAH BRAUN
(b) Address WESTMINSTER, MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-22-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila RD + HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E Balto St.

19 JUL 24 1945 (Date received by Registrar) Huntington Williams, MD

MEDICAL CERTIFICATION 18

20. DATE OF DEATH 7-20-45 19 , at 11 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from July 19 1945 to July 20 1945 and that I last saw h-r alive on July 19 1945.

Immediate cause of death Coronary Thrombosis — Duration 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar A. Mitchell M.D.
Address 2623 Loch. Blvd Date signed 7/22/45

VS 150

X

C30986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128

Registered No. C30986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmont
(c) Hospital or institution: The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore-22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7424 HOLABIRD AVE. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** CLARA RACHEL ROE

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	WIDOW

6 (b) Name of husband or wife NOT KNOWN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JANUARY 5, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	18	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business AT HOME.

FATHER
12. Name JOHN DUKES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name AMANDA BERTON
15. Birthplace MARYLAND.

16 (a) Informant MRS. H. PLUMMER (DAUGHTER)
(b) Address 861 HERODON COURT, BALTO-25, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26-45 (month) (day) (year)
(c) Cemetery or crematory Centerville
Location Centerville Md

18 (a) Funeral director Edley & Lane
(b) Address Church Hill Md

19 JUL 24 1945 (Date rec'd by registrar) (b) Huntingtown Williams, Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 7.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to July 23 1945, and that I last saw HER alive on July 23 1945

Immediate cause of death	Duration
SHOCK & ACIDOSIS	
Due to ACUTE HEMORRHAGIC PANCREATITIS	36 HRS.
Due to	
Other Conditions DIABETES.	

(Include pregnancy within 3 months of death)

Date of operation 7-22-45

Major findings of operation: BLOOD IN PERITONEAL CAVITY.

of autopsy ACUTE HEMORRHAGIC PANCREATITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address The Church Home & Hosp. Date signed 7-24-45

VS 150

X

G30987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G30987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Gertrude Luty Luty

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thomas Luty

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 23 1881

8. AGE: Years 64 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Yorkshire England (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Martin Butler
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah England
15. Birthplace ?

16 (a) Informant Thomas Luty
(b) Address 2411 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Pratt & B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) JUL 24 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23/45 19 , at 2:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1945 to 7/23, 1945. and that I last saw her alive on 7/23 1945.

Immediate cause of death Cardio Respiratory failure — Duration

Due to Arteriosclerosis C-V-D. & Chronic

Due to Nephritis

Other Conditions Nil

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Corbett Jr. M. D.
Address 22 S. Agnes Hosp Date signed 7/23/45

X

G30988

CWK-93604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G30988

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 8-
(e) Length of stay in Baltimore (yrs., mos., or days) 64- 8- 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4919 O'Donnell Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Bohle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28-1880

8. AGE: Years	Months	Days	If less than one day
64	8	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gustuf Bohle (D)
13. Birthplace Holland

MOTHER
14. Maiden Name Anna ?? (D)
15. Birthplace Holland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/45 (month) (day) (year)
(c) Cemetery or crematory Schmaltz
Location O'Donnell St

18 (a) Funeral director Clarence P. Hoffman
(b) Address 1639 N. Broadway

19 (a) [illegible] Huntington Williams, M.D.

JUL 24 1945

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 22 1945, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945, to July 22 1945, and that I last saw h. in alive on July 22 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Hepatic insufficiency	
Due to Cirrhosis of liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address [illegible] Date signed 7/22/45

G30989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G30989 / 469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2565 W. Fairmount Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2565 W. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace L. Hucke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Late John A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1885

8. AGE: Years	Months	Days	If less than one day
60	2	1	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER 12. Name — Spare
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Mr. John Hucke
(b) Address 2565 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave.

19 JUL 24 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 44 to July 23 19 45, and that I last saw h alive on July 20 19 45.

Immediate cause of death Carcinoma of Sigmoid. Carcinomatosis of Liver

Duration Months 6 Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. G. Mayo M. D.
Address 716 Cathedral St. Date signed 7-24-45

G30998 (3)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G30930 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County V
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 S Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H. Leightler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ada Hartlove

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1887

8. AGE: Years	Months	Days	If less than one day
62	10	-	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Leightler
13. Birthplace Md

MOTHER
14. Maiden Name Annie M. Blunt
15. Birthplace Md

16 (a) Informant Mrs Ada Hartlove
(b) Address 1323 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Kitzler
(b) Address 4101 E Monument St

19 (a) JUL 24 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1945 to July 22 1945 and that I last saw him alive on July 22, 1945.

Immediate cause of death Uremia -

Due to Chronic Nephritis

Due to Alcoholism

Other Conditions Arteriosclerosis -
(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation:

of autopsy: -

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Glass M. D.
Address 876 Walker St Date signed 7/25/45

G30991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148-B

G30991

Registered No. VA 14662

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Park Drive 11

(c) Hospital or institution: U. S. Marine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days 9 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 10 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 205 W. Madison Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Evelyn Bailey

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1882

8. AGE: Years 62 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace Crum Point, New York (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Elias Bailey

13. Birthplace Massachusetts

MOTHER 14. Maiden Name Jane Ford

15. Birthplace Ireland

16 (a) Informant Records - U. S. Marine Hospital

(b) Address

17 (a) Removal - [illegible] (Burial, cremation, or removal) Date thereof 7/24/45 (month) (day) (year)

(c) Cemetery or crematory

Location New York City

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUL 24 1945 (Received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH July 22 1945, at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to July 22 1945, and that I last saw h[illegible] alive on July 22 1945.

Immediate cause of death Metastatic carcinoma of the broad ligament — Duration 6 years

Due to

Due to

Other Conditions Adenocarcinoma of the uterus (Include pregnancy within 3 months of death)

Date of operation Paracentesis 6/21/45

Major findings of operation:

of autopsy: None done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John L. Wilson M. D.

Address U. S. Marine Hospital Baltimore 11, Maryland. Date signed 7/23/45

VS 150

G30992 Ruppel G30992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2032 E Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E Fayette st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Ruppel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (town, county, and state)

10. Usual Occupation Shucker

11. Industry or business

FATHER 12. Name Leo Ruppel

13. Birthplace Germany

MOTHER 14. Maiden Name Mary

15. Birthplace Germany

16 (a) Informant Eddie Katowich

(b) Address 2032 E Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Frank Brackbein

(b) Address 900 N. Eberdale

19 1945 (Date rec'd by reg.) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to July 23 1945. and that I last saw h alive on July 23 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Causes unknown

Due to

Other Conditions Carcinoma of prostate

(Include pregnancy within 3 months of death)

Date of operation 7/23/45

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin Rudo M. D.

Address Sinai Hospital Date signed July 23 45

VS 180

G30993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓467

Registered G30993

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 15
(d) Street No. 5723 Uffington Road. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRED E. KUFF.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Ruth M. Kuff.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1899.

8. AGE: Years	Months	Days	If less than one day
45 46	11	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Manufacturer.
11. Industry or business Galvanized Products.

FATHER
12. Name Moses Kuff.
13. Birthplace Russia.

MOTHER
14. Maiden Name Celia Coplin.
15. Birthplace Russia.

16 (a) Informant Mr. H. L. Morvitz.
(b) Address 5723 Uffington Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7.25.45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) JUL 24 1945 (Registrar's signature) 5th Uffington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 19 45 at 11 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to July 23 1945. and that I last saw him alive on July 23 1945.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Metastases from Carcinoma of the recto sigmoid bowel	
Due to	
Other Conditions Multiple metastases to liver, peritoneum & other viscera	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel A. Hamburger M.D.
Address Sinai Hospital Date signed 7/24/45

VS 199

G30994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1710 C

G30994 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Urbeck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 23 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 24 1945 (Date rec'd by registrar) [illegible] Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1945, at 10 a. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage, traumatic
Fracture of legs
Due to Fracture of pelvis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7/4/45 at 11:45 P. M. 10/1

(b) Where did injury occur? Preston & East Valley St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian struck by auto.

23. Signature Robert L. Gaston M.D. Medical Examiner.

Date signed July 6 1945

VS 151

362

G30995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G30995 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 N Lexington
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 N Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Siltman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Herman H Siltman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 186

8. AGE: Years 78 | Months 10 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ger. Gutman
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Ely Warfield
(b) Address 2002 N Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director F B Wipperman Son
(b) Address 200 Eutaw Place

19 (a) 7/24/45 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 4 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1944 to July 21 1945
and that I last saw h alive on July 21 1945

Immediate cause of death	Duration
Mitral Stenosis	10 yrs
Due to Arteriosclerosis	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vernon H Gordon M. D.
Address 3210 Howard St Date signed 7/24/45

VS 100

G30996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G30996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1606 St Stephen St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 St Stephen St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Hale

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Horace D Hale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8/1868

8. AGE: Years	Months	Days	If less than one day
76	11	16	hr. min.

9. Birthplace Lancaster Co Va (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Stephen Dayne
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Ann Dudley
15. Birthplace Virginia

16 (a) Informant Mary Hale Long
(b) Address 2948 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/1945 (month) (day) (year)
(c) Cemetery or crematory Bethel M E
Location Lancaster Co Va

18 (a) Funeral director Harry H Armacost
(b) Address 4204 Edgewood Ave

1945 July 24 (Date rec'd by registrar) Huntington Williams M D

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942, to July 24 1945, and that I last saw h er alive on July 24 1945.

Immediate cause of death	Duration
Coronary Sclerosis	Indef.
Due to General Arteriosclerosis	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J E Schmidt M. D.
Address 2924 Brighton Date signed 7-24-45

VS 150

G30997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G30997 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Ausquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond E Marsh

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Edna E. Marsh

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) April 24 1906

8. AGE: Years 39 Months 7 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Prop. Restaurant

FATHER 12. Name James E. Marsh

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Ada E Hill

15. Birthplace Baltimore Md.

16 (a) Informant Edna E. Marsh (wife)

(b) Address 2511 Ausquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1416 Light St.

19 (a) (Date received by registrar) (b) Registrar

7-24-1945 Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945 at 12:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 22 1945, and that I last saw him alive on July 22 1945.

Immediate cause of death Internal hemorrhage

Due to Ruptured esophageal varices

Due to Cirrhosis of the Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
esophageal

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Cordell M. D.

Address Md. Gen. Hosp. Date signed 7-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G30998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G30998 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ella Flynn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15 1879

8. AGE: Years	Months	Days	If less than one day
66	10 9	8	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Patrick Flynn
13. Birthplace Ireland

MOTHER 14. Maiden Name Anny McHale
15. Birthplace Irelnd

16 (a) Informant Mrs Nora Green
(b) Address 211 N. Rutland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanigan
(b) Address 1426 Light St.

19 (a) A 1945 (Date rec'd by registrar) (b) Thurlow for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23/45 19 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1945 to 7/23 1945 and that I last saw h[illegible] alive on 7/23 1945.

Immediate cause of death Cardia Respiratory failure — Duration
Due to Arterio sclerotic Cardio Vascular Lesions
Due to
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cleff Follett Jr. M.D.
Address St. Agnes Hosp Date signed 7/25/45 M. D.

VS 150

93D

G30999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G30999 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Callow Ave
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ellis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Philip Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Leah ?
15. Birthplace Russia

16 (a) Informant Mr Ellis Cohen
(b) Address 2122 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JUL 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to July 24 1945, and that I last saw h[illegible] alive on July 24 1945.

Immediate cause of death Carcinoma of Lung — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Cohen M.D.
Address 1921 W North Ave Date signed 7/25/45 M. D.

X

G31000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G31000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Brantley ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Brantley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Garfield Burrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	M.

6 (b) Name of husband or wife Dorris Burrell
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) April 7, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	14	hr. min.

9. Birthplace Richmond, [redacted] VA. (Town, county, and state)
10. Usual Occupation WAITER
11. Industry or business

FATHER 12. Name Lewis C. Burrell
13. Birthplace Va

MOTHER 14. Maiden Name Mollie Brown
15. Birthplace Va

16 (a) Informant Dorris Burrell
(b) Address 1017 Brantley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) Huntington, W. Va. (Date received by Registrar) JUL 25 1945

VS 150

MEDICAL CERTIFICATION 7/21/45 1130 A M

20. DATE OF DEATH 7/24/45 19 at 1130 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1945 to 7/24 1945 and that I last saw alive on 7/24/45 19

Immediate cause of death Cerebral hemorrhage

Due to (a) Arteriosclerosis

Due to (b) Cardiac Vascular Dis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Noville
Address 601 N. Carrollton Ave. Date signed 7/24/45

W.F. NOVILLE X

G31001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

G31001 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Maryland Gen'l. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Ryan Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	19	hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Samuel Ward
13. Birthplace Md.

MOTHER 14. Maiden Name Mary
15. Birthplace Md.

16 (a) Informant Bettie Ward
(b) Address 927 Ryan Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Adolphus Halstead
Address 948 Druid Hill Ave.

19 (a) JUL 25 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945, at 2:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of Aorta

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gantz M.D. Medical Examiner.
Date signed July 24, 1945

G31002 MAKfield

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G31002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 N Eutaw
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 N Eutaw (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Mayfield

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-3103

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1878

8. AGE: Years 67 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Mitchell Mayfield

13. Birthplace Md.

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Wakes

(b) Address 633 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

19 (a) JUL 25 1945 (Date received by Registrar) (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 8 P M

21. I certify that death occurred on the date above stated, and I last attended deceased from July 19 1945 to July 21 1945 and that I last saw him alive on July 21 1945

Immediate cause of death: Cerebral thrombosis — Duration 2 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 744 Eutaw Date signed 7-31-45

G31003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G31003

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Md.
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1816 Division Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business B. & O. R.R. Co.

FATHER
12. Name George Monroe
13. Birthplace Md.

MOTHER
14. Maiden Name Gertrude Wilson
15. Birthplace ?

16 (a) Informant Gertrude Monroe
(b) Address 19 E. Ware St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JUL 25 1945 Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1945 at 12:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-20-45 at M.
(b) Where did injury occur? Oakland Park Cafe Randallstown Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public ; While at work? No.
(d) Means of injury Shooting.

23. Signature Roland Lee Gutcher M.D.
Medical Examiner.
Date signed July 21, 1945.

VS 151

G31004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G31004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 874 Washington Blvd

(c) Hospital or institution: Doctors Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 513 Wyeth St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Creamer

3 (b) If veteran, name war: NR

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 21 1945

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER 12. Name: Lawrence Creamer

FATHER 13. Birthplace: Baltimore Md

MOTHER 14. Maiden Name: Carletta Harden

MOTHER 15. Birthplace: Kentucky

16 (a) Informant: George L. Creamer

(b) Address: 156 N Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/25/45 (month) (day) (year)

(c) Cemetery or crematory: Cedar Hill

Location: Lyndhurst Md

18 (a) Funeral director: William Cook Inc

(b) Address: 1219 E Lanvale St

19 (a) Date received: JUL 25 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21, 1945, to July 23 1945; and that I last saw h alive on July 23 1945.

Immediate cause of death: Congenital stenosis of intestine

Due to: Congenital

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Louis Glass M.D.

Address: 26 Walbrook Ave Date signed: 7/24/45

G31005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G31005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S Durail St #24 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Ann Henderson

3 (b) If veteran, name war: N

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1945

8. AGE: Years	Months	Days	If less than one day
6 days			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Thomas Henderson

13. Birthplace Winfield, Ala

MOTHER 14. Maiden Name Hazel Irene Logue

15. Birthplace Lookcreek, W. Va

16 (a) Informant Mother Hazel Henderson

(b) Address 806 S Durail St-24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Towson, Md

18 (a) Funeral director Wilson Lochner

(b) Address 1211 E Monument St

JUL 25 1945 (Date received by Registrar) Huntington for Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19, 1945 to July 24, 1945 and that I last saw her alive on July 24, 1945

Immediate cause of death

Due to premature birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature of Dr. Seaman M. D.
Address Sinai Hospital Date signed 7/24/45

G31006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G31006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1826 W.Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 W.Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry W.Finecey

3 (b) If veteran, name war --

3 (c) Social Security Account No. 218-01-0467

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.7,1904

8. AGE: Years 40 | Months 19 | Days 17 | If less than one day hr. min.

9. Birthplace Balto.Md. (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER
12. Name James W.Finecey
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Margaret Bell
15. Birthplace Balto.Md.

16 (a) Informant Mrs.Margaret Finecey
(b) Address 1826 W.Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.Park
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) Date received by local registrar JUL 25 1945 Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24/45 19 , at 8.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1945, to July 24 1945 and that I last saw him alive on July 24 1945

Immediate cause of death Bilateral Bronchopneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H.B. Friedman, M.D.

Address 1319 Cajer 28, Date signed 7/26/45

X

G31007 Collier

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B

G31007 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4543 Pimlico Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4543 Pimlico Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Mae Collier

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-3865

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1902

8. AGE: Years 43 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Clerk optica
11. Industry or business Work Ins. Co.

FATHER 12. Name John R. Collier
13. Birthplace Balto

MOTHER 14. Maiden Name Margaret Brown
15. Birthplace West Va

16 (a) Informant Margaret Collier (mother)
(b) Address 4543 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 45 (month) (day) (year)
(c) Cemetery or crematory Mount Olive
Location Randallstown

18 (a) Funeral director Mark K. Duppel
(b) Address 7110 Belair Rd

19 (a) Date received JUL 25 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945 at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from saw her one wk before death 19 to 19, and that I last saw her alive on July 23 1945.

Immediate cause of death Metastatic Carcinoma (originated at ankle) — Duration 7 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Enson M. D.
Address 7201 York Rd Date signed 7-24-45

Patient in Sinai Hosp. M.A. X

VS 180

G31008 387413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G31008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Craven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	C	S

6 (b) Name of husband or wife Wm Craven

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-23-17

8. AGE: Years	Months	Days	If less than one day
27	7	28	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Truxton
13. Birthplace Md

MOTHER
14. Maiden Name Beulah Marsh
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)
(c) Cemetery or crematory Fairview Memorial Park
Location Baltimore Md

18 (a) Funeral director Archibald E. Gaddis
(b) Address 2101 McCulloh St.

19 (a) JUL 25 1945 (Date rec'd by Registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 10 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20- 1945 to 7-21- 1945 and that I last saw her alive on 7-21- 1945

Immediate cause of death	Duration
Respiratory failure due to	
Cardiac failure	
Due to Lupus Erythematosis disseminata — 10 yrs	
Due to and Bronchopneumonia 2 days	

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William T. Dixon M. D.
Address Johns Hopkins Hospital 7/22/45

VS 150

G31009 Social Security Number 212-18-5301 ✓ G31009

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

927

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4413 Ivan hoe Ave Ward 10) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Colliamson Page If U. S. Veteran specify WAR

(a) Residence: No. 4413 Ivanhoe St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Pinkett Page

6. DATE OF BIRTH (month, day, year) 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janitor

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Roland Page

14. BIRTHPLACE (city or town) (State or country) Va

MOTHER

15. MAIDEN NAME Adele Page

16. BIRTHPLACE (city or town) (State or country) Va

17. INFORMANT Mrs. Pinkett Page

(Address) 4413 Ivanhoe Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Columbia Cemetery Date Jul 25 45

19. UNDERTAKER Frederick C. Gaddis

(Address) 2101 W. Baltimore St.

20. Filed Jul 25 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 7-22-45, 19

22. I HEREBY CERTIFY, That I attended deceased from April 20, 1945, to July 22, 1945

I last saw him alive on July 21, 1945 Death is said to have occurred on the date stated above, at 5:30 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular Heart Disease	April 1945
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Physical Diagnosis Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Hunt Williams M. D.

(Address) 2401 E. Baltimore St

X

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 3

G31010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G31010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude T. Miller (Gertrude Taylor Miller)

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Turner Ashbey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1898

8. AGE: Years 46 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Haverhill, Mass.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Martin Ellison Taylor
13. Birthplace Haverhill, Mass.

MOTHER
14. Maiden Name Gertrude Talbot
15. Birthplace Lowell, Mass.

16 (a) Informant Mrs. Robert F. Whitmer
(b) Address Lake Ave., Greenwich, Conn.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/25/45 (month) (day) (year)
(c) Cemetery or crematory Linwood,
Location Haverhill, Mass.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 7-25-1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1945, at 7.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1945 to 7/24 1945
and that I last saw her alive on 7/24 1945

Immediate cause of death: Uremia

Due to: Acute nephritis
Cirrhosis of liver

Due to: Alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Follett, Jr. M. D.
Address St. Agnes Hosp Date signed 7/24/45

X

G31011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 E. 30th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1624 E 30th St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Mary Westphale

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John H. Westphale
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept 20th 1882

8. AGE: Years	Months	Days	If less than one day
62	10	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John H. Weber
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Kurtz
15. Birthplace Baltimore

16 (a) Informant John H. Westphale
(b) Address 1624 E 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Windsor Mill Road

18 (a) Funeral director Welsh Funeral Home
(b) Address 2946 Orleans St

19 (a) JUL 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1945, to July 23 1945; and that I last saw alive on July 23 1945.

Immediate cause of death	Duration
Coronary artery occlusion	9 days
Due to Moderately degen. arteriosclerosis	10 yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R. Straight M.D.
Address 10 E Biddle St Date signed July 25 1945

VS 150

G31012

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G31012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 E. Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mendel Zemel also known as Max Zemel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, or state)

10. Usual Occupation Conf Store

11. Industry or business

FATHER 12. Name Hymon
13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Ida Zemel
(b) Address 2000 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-45 (month) (day) (year)

(c) Cemetery or crematory Levering Mem Park
Location Dorsey Lane & Philadelphia Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) JUL 25 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 5 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943 to July 24 1945 and that I last saw h[illegible] alive on July 24 1945

Immediate cause of death Coronary occlusion — Duration: 1 hour

Due to Coronary Sclerosis — Duration: 4-5 yrs

Due to Arterio sclerosis & hypertension

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Herman Seidel M.D.
Address 2404 Ellamont Date signed 7/25/45

VS 180

W31013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

✓ G31013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days): 6 - 4
(e) Length of stay in Baltimore (yrs., mos., or days): 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
City or town: Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1824 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No): ✓
If yes, name country:

3 (a) FULL NAME: Morris Flom

3 (b) If veteran, name war: —

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Tuba

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years: 73 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Judah Flom
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah
15. Birthplace: Russia

16 (a) Informant: Hospt Records
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-25-45 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Phila Rd - Hamilton Ave

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E. Balto St

19 (a) 7-25-1945 (Date received by local registrar) (b) Huntington Hollow, Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-24-45 19..., at 8:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19-1945 to 7-24-1945, and that I last saw him alive on 7-24-1945.

	Duration
Immediate cause of death: Lobar pneumonia	
Hypertensive & Arteriosclerotic Heart disease	
Due to:	
Due to:	
Other Conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Bertha Rader M. D.
Address: Sinai Hosp. Date signed: 7/26/45

108

G31014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G31014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3825 Braunther Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3825 Braunther Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah V. McKnew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles A. McKnew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1857

8. AGE: Years	Months	Days	If less than one day
88	2	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name James Smith.
13. Birthplace ?

MOTHER
14. Maiden Name Hannah Cook.
15. Birthplace ?

16 (a) Informant George W. Smith
(b) Address 3825 Braunther Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.

18 (a) Funeral director Benjamin H. Donovan
(b) Address 3615-17 Chestnut Ave.

19. (a) Date received July 26 1945 (b) Registrar Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 to 7/25 1945 and that I last saw h[illegible] alive on 7/24 1945

Immediate cause of death Hypostatic pneumonia — Duration 4 days

Due to fractured hip — 3½ mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence March at 1945 — M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? House (Specify type of place) While at work?
(e) Means of injury Fall on floor

23. Signature [signature] M. D.
Address 2210 N. Charles Date signed

Approved. Robert Lee Taylor M.D. × 7/26/45

G31015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31015

Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts.
(c) Hospital or institution: Univ. of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Da
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore North
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Nuth Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CONRAD WIELAND

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-01-3214

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ~~Elizabeth Handle~~ Jeannie Wieland 6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 22, 1886

8. AGE: Years 59 | Months | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER 12. Name Fred Wieland
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Elizabeth Handle
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Jennie Wieland
(b) Address 5206 Nuth Ave.

17 (a) Parkwood (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director H. Sander & Sons Inc.
(b) Address North Ave. & Broadway

19 (a) JUL 25 1945 (Do not write) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1945 at 4:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945 to July 24 1945, and that I last saw him alive on July 23 1945.

	Duration
Immediate cause of death Uremia	
Due to Hypertensive Cardio-vascular-renal disease	
Due to	
Other Conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roy H. Watt, Jr. M. D.
Address Univ. Hosp. Date signed 7/24/45

VS 150

476 G34016

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 61

G31016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Stevenson. (If outside city or town limits, write RURAL and give town)

(d) Street No. Greenspring Avenue (If rural give location)

(e) Citizen of foreign country? C (Yes or No)

If yes, name country

3 (a) FULL NAME Myra Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No. C

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White.	married

6 (b) Name of husband or wife Albert.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-74.

8. AGE: Years	Months	Days	If less than one day
71	3	18	hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home-mfr.

11. Industry or business At Home

FATHER

12. Name Marion D. Geist

13. Birthplace Md.

MOTHER

14. Maiden Name Rose E. Joyce

15. Birthplace Md

16 (a) Informant Reeves

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Geist Church Cem.

Location Shawan, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons

(b) Address Towson, Md.

19 (a) JUL 25 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 24 1945 at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 8 1945 to July - 24 1945 and that I last saw h alive on July - 24 1945.

Immediate cause of death	Duration
CONGESTIVE FAILURE	
Due to ARTERIOSCLEROSIS	
Due to	
Other Conditions DIABETES MELLITUS BRONCHOPNEUMONIA	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Dixon

Address Johns Hopkins Hospital Date signed 7/27/45

VS 150

97

G31017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State md. (b) County

(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)

(d) Street No. 619 N. Mount St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Gray.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9. 21. 1881

8. AGE: Years 63. Months 10 Days 2 If less than one day hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Gray.

13. Birthplace md.

MOTHER 14. Maiden Name Augusta Whiting

15. Birthplace md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive

Location Reno Va.

18 (a) Funeral director Chas. F. Alexander

(b) Address 927. N. Mount st.

JUL 25 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH July. 23. 1945, at 11.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July. 23 1945, to July 23 1945, and that I last saw him alive on July. 23 1945.

Immediate cause of death: Uraemia, acute pulmonary edema.

Due to: Urinary obstruction.

Due to: Benign prostatic hypertrophy. — Duration: 2 years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William J. Dixon

Address Johns Hopkins Hospital Date signed 7/29/45

VS 150

X

631018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 631018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Parry St
(c) Hospital or institution: D St Parish

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Parry St (If rural give location)
(e) Citizen of foreign country? N Parish (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Porter in Lunch Room

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Ruth
(b) Address 1127 N. Parrish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)
(c) Cemetery or crematory National Balto
Location Balto. Md.

18 (a) Funeral director Chas H. Alexander
(b) Address 927 N. Mount St

19 (a) JUL 25 1945 (b) Huntington Williams (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. Sulewski M.D. (Medical Examiner.)
Date signed 7/24/45

G31019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 N. Dallas ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N. Dallas ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Bundy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age 17 years

7. Birth date of deceased (mo., day, yr.) Nov. 1892

8. AGE: Years	Months	Days	If less than one day
52	8	5	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Bundy
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Hayman
15. Birthplace Frederick Md

16 (a) Informant Ida Holly
(b) Address 609 N. Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Byron Dyson & Harris
(b) Address 721 Aisquith St

19 (a) July 25 1945 (Date received by Registrar) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945, at 8 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to Extreme obesity

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed July 22 1945

VS 151

G31020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1477

G31020

Registered No.

CWK-94846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 328 N. Pine Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

29122

3 (a) FULL NAME Fannie Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16-1912

8. AGE: Years	Months	Days	If less than one day
32	9	5	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business

FATHER
12. Name Henry Murphy
13. Birthplace Va.

MOTHER
14. Maiden Name Caroline Sykes
15. Birthplace Va.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 7/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Filed 7-25 1945 (b) Registrar Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 21- 1945, at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19- 1945 to July 21 1945, and that I last saw h.. alive on July 21 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	2hr.
Due to Pulmonary Embolism	
Due to	
Other Conditions Pregnancy delivered at term (Include pregnancy within 3 months of death)	over

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Perry Jr. M.D.
Address Balto City Hosp Date signed 7/23/45

X

G31021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Riggs Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864 April 6

8. AGE: Years 81 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Anna Arundel Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Galloway
13. Birthplace A.A. Co. Md.

MOTHER
14. Maiden Name Mary
15. Birthplace A.A. Co Md.

16 (a) Informant Walter Chase
(b) Address 1717 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion,
Location

18 (a) Funeral director Mrs Zatta R. Williams
(b) Address 322 N. Schroeder [illegible] Washington Boulevard

JUL 25 1945
(Date Local Registrar)

(Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1945, at 1 [illegible]

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1945 to 7-22 1945, and that I last saw h alive on 7-22 1945

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 7-24-45

G31022 Julia JULIA C. COLSON G31022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. 38th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia C. Colson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced Widow

6 (b) Name of husband or wife Marion A. Colson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12-1871

8. AGE: Years 74 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

MOTHER / FATHER
12. Name — Rodenpeiser
13. Birthplace Maryland
14. Maiden Name Elizabeth Smith
15. Birthplace Maryland

16 (a) Informant Walter H. Colson
(b) Address 905 N. 38th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Mary's Hampden
Location Baltimore Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 25 1945 (Registrar) (b) Huntington Williams M.D. (Local Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1945, at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1945, to 7/23 1945, and that I last saw h[illegible] alive on 7/23, 1945.

Immediate cause of death [illegible] Duration

Due to bronchopneumonia

Due to

Other Conditions [illegible] arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation [illegible]

Major findings of operation: [illegible]

of autopsy: bronchopneumonia [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Coles M. D.
Address Franklin Square Hosp. Date signed 7/25/45

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G31023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31023
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 E. 33rd St.
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3726 Falls Road - City
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Cameron Lea Ford

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-3325

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced Undivorced

6 (b) Name of husband or wife

6 (c) If alive, give age (d) years

7. Birth date of deceased (mo., day, yr.) April 8-1899

8. AGE: Years	Months	Days	If less than one day
46	3	16	6 hr. 0 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas H. Ford

13. Birthplace Maryland (?)

MOTHER 14. Maiden Name Annie E. Fisher

15. Birthplace Maryland (?)

16 (a) Informant Mrs. Talbot Ford

(b) Address City (Brother)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27-1945 (month) (day) (year)

(c) Cemetery or crematory Poplar Hill

Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3231 Falls Road

19 (a) 1945 (b) [illegible] by registrar Washington Williams, M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945, to July 24 1945, and that I last saw him alive on July 23 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Arterio-sclerotic Heart Disease.	?
Due to	
Other Conditions Diabetes Mellitus	14 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Hopkins III

Address Union Memorial Hospital Date signed 7/24/45 M. D.

VS 150

937

G31024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

Registered No. G31024

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 03 E + Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 N. Calvert (If rural give location)
(e) Citizen of foreign country? No (or No) If yes, name country

3 (a) FULL NAME Frank Cox

3 (b) If veteran, name war * *

3 (c) Social Security Account No. 154-05-2072

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/22/85

8. AGE: Years	Months	Days	If less than one day
60	1	28	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Frank Cox
13. Birthplace Ireland

MOTHER
14. Maiden Name Marie Corbett
15. Birthplace Ireland

16 (a) Informant Frank Cox
(b) Address 2602 N. Calvert St., Balto 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) JUL 25 1945 Registrar (b) Washington Millimet M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1945 to 7/20 1945 and that I last saw him alive on 7/20 1945.

Immediate cause of death	Duration
Respiratory - condroi infarct	1 hr.
Due to	
Due to	
Other Conditions Ca of stomach	1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt. Col. Logsdon Jr. M. D.
Address Union Memorial Date signed 7-21-45

VS 150

X

G31025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

165

G31025 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6707 Duluth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Haney

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-9-1945

8. AGE: Years | Months | Days 1 | If less than one day: living hr. min.
Full Term Fetus

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William Hudson
13. Birthplace U. S.

MOTHER
14. Maiden Name Bonnie L. Haney
15. Birthplace Montebello N.C.

16 (a) Informant Birth Certificate
(b) Address # G-37329

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUL 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 25 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

KO

20. DATE OF DEATH June 10, 1945, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-9-45 at ? M.
(b) Where did injury occur? 6707 Duluth Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Undetermined.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6-11-45

VS 151

G31026

JO #93610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31026

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Baltimore City Hospitals 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 145 W. Henrietta St. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Jeff Spruell

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1899

8. AGE: Years	Months	Days	If less than one day
45	9	7	..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Jacob Spruell (d)

13. Birthplace N. C.

MOTHER

14. Maiden Name Mary Sikes

15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/25/45 (month) (day) (year)

(c) Cemetery or crematory Capron

Location Virginia

18 (a) Funeral director Isaiah L. Brunson

(b) Address 108 W. Montgomery St. Huntington Williams, Md.

JUL 25 1945 (Rec'd by registrar) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14, 1945, to July 22, 1945, and that I last saw him alive on July 22, 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature Robert B. Garland Jr. M. D.

Address Balto. City Hosp. Date signed 7/24/45

G31027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163E

G31027 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 N. Howard Street
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 N. Howard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE WALLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace Charlottesville Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name of Lizzy Walles
13. Birthplace Va

MOTHER
14. Maiden Name Ella Lewis
15. Birthplace Va.

16 (a) Informant Inez Michie
(b) Address 2418 N. Howard st

17 (a) [illegible] (b) Date thereof 7-27-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Charlottesville Va

18 (a) Funeral director Clay O. Wilson
(b) Address 1000 Brantley ave

19 (a) 7-25 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1945, at 7:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Strychnine poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-25-45 at 6:30 A. M.
(b) Where did injury occur? 2418 N. Howard Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of strychnine

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 26 1945

VS 151

X

G31028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31028

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County Dauphin
(c) City or town Stalton Pa
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Carnes

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Carnes 6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Gay (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business Jas. S. Wemyss Express

FATHER
12. Name D K
13. Birthplace

MOTHER
14. Maiden Name D K
15. Birthplace

16 (a) Informant —
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28-45 (month) (day) (year)
(c) Cemetery or crematory Stratton Pa
Location Baldwin Cemetery

18 (a) Funeral director Williams Cobb Sons
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams (b) Date filed by registrar 7-31-45

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1945 to 7-25 1945 and that I last saw him alive on 7-25 1945

Immediate cause of death Surgical Shock — Duration Hours

Due to Fatal Hemorrhage from Ruptured Duodenal Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-25-45

Major findings of operation: Ruptured Duodenal Ulcer

of autopsy: Refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James H. Lindenstruth M. D.
Address University Hospital Date signed 7-25-45
Baltimore, Md

G31029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G31029 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Freyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19th 1864

8. AGE: Years 81 | Months — | Days 5 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Christian Kehn
13. Birthplace Penna

MOTHER
14. Maiden Name Annal Ferrill
15. Birthplace Ireland

16 (a) Informant Mr Freyer
(b) Address 2101 Belair Road

17 (a) (Burial, cremation, or removal) (b) Date thereof July 26th 1945
(month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Leo G. Leo ok
(b) Address 1701-03 N. Patterson Park Ave

19 (a) 7/26 1945 (b) registered by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24th 1945, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 24 1945, and that I last saw h[illegible] alive on July 24 1945.

Immediate cause of death Gastric Collecturan — Duration

Due to

Due to

Other Conditions Chr. Myocarditis Arteriosclerosis

(Include pregnancy within 3 months)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Seamount Ave Date signed 7/25/45

G31030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. G31030

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Tunbridge Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Tunbridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Morgan Hunter

3 (b) If veteran, name war: W.W. 1

3 (c) Social Security Account No. 216-07-4726

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lola E. Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1894

8. AGE: Years 51 | Months 5 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Time Keeper

11. Industry or business Bethlehem Steel

FATHER
12. Name William J. Hunter
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden Name Josephine Morgan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lola E. Hunter
(b) Address 517 Tunbridge Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7- - 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Chas E. Franck
(b) Address 5701 Rockspring Road

19 (a) (Date rec'd by registrar) Huntington Williams, Registrar

JUL 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1945, at 8.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26 1945, to July 23 1945, and that I last saw h[illegible] alive on July 22 1945

Immediate cause of death: Hodgkins Disease — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hart H Bevan, M.D.

Address 5111 York Rd Date signed 7/24/45

G31031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167 ✓

G31031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jermit Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James W Brown
13. Birthplace Md

MOTHER 14. Maiden Name Katie Hawkins
15. Birthplace Md

16 (a) Informant Elizabeth Brown
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUL 26 1945 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 19 45, at 12:45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound
7 Lg: Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12:30A at 7-21-45 M.
(b) Where did injury occur? alongside 8 1416 Laurens Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Stabbed

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed July 21, 1945

X

G31032

AB-94945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31032 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 559 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

S 33008

3 (a) **FULL NAME** Evelyn Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) ?-?-? 31?

8. AGE: Years 31? Months ? Days ? If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Willie Prestley
13. Birthplace S.C.

MOTHER 14. Maiden Name Susan Prestley
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)
(c) Cemetery or crematory King's street
Location South Carolina

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 JUL 26 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 2.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23- 1945 to 7-24 1945, and that I last saw her alive on 7-24- 1945

Immediate cause of death: Acute Cardiac Failure
Diabetic acidosis
Due to: Diabetes
Due to:
Other Conditions: Pregnancy, delivered
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Same
of autopsy: Same

Duration: 12 hrs. 160 hrs. 2 yrs (-) over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Perry Jr. M.D. M. D.
Address Balto City Hosp Date signed 7/26/45

X

G31033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G31033

CWK-94827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1835 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Vass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Estelle Vass
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1-1892

8. AGE: Years	Months	Days	If less than one day
53	1	20	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Vass
13. Birthplace N. C.

MOTHER
14. Maiden Name Sarah Vass
15. Birthplace N. C.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26th 1945 (month) (day) (year)
(c) Cemetery or crematory Wash. Cem.
Location Washington N. C.

18 (a) Funeral director Brasfield & Agnis H. Wright
(b) Address 721 Biscuit St. Huntington Williams, W. Va.

19 JUL 26 1945 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1945, to July 21 1945, and that I last saw him alive on July 21 1945.

Immediate cause of death	Duration
Cardiac failure	3
Due to Hypertensive Heart Disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Enlarged Heart, Congestive Failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. R. Jernigan M. D.
Address Baltimore City Hosp. Date signed July 23 1945

X

G31034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G31034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Bunker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard E. Chisley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar-12-1914

8. AGE: Years	Months	Days	If less than one day
31	4	11	hr. min.

9. Birthplace Waldorf - Md. (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name West Chisley
13. Birthplace Md (Howard Co)

MOTHER
14. Maiden Name Agnes Thomas
15. Birthplace Howard (Md) Co

16 (a) Informant University Records
(b) Address Redwood + Greene Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 July 26 1945 (Signature of local registrar) (b) Huntingtor Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945, at 12:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16/ 1945, to 7/23 1945, and that I last saw h[illegible] alive on 7/23 1945

Immediate cause of death	Duration
Cardiac failure	5 days
Glomerulo	
Due to Chronic Glomerulo-nephritis	Unknown
& Uremia	
Due to Hypertensive Cardio-Vascular	Unknown
Renal Disease	
Other Conditions Cardiac Enlargement	Unknown
Anemia (Hemorrhagic)	

(Include pregnancy within 3 months of death)

Date of operation 7-7-45
Major findings of operation: Calculus of left ureter.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Carl Ebeling M.D.
Address Univ. Hosp. Date signed 7-27-45

X

G31035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 78 B

Registered No. G31035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs. 4 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) ~~State~~ Maryland (b) County

(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 221 Carrollton Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Josephine Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1937

8. AGE: Years	Months	Days	If less than one day
7	4	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER 12. Name John Brown

13. Birthplace Georgetown, S.C.

MOTHER 14. Maiden Name Ruth Jadge

15. Birthplace Baltimore, Md.

16 (a) Informant Parents

(b) Address 221 Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 19 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Rose R. Williams

(b) Address 3221 Lehmeque St

19 JUL 26 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1945, at 6 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1945 to July 23, 1945. and that I last saw h[illegible] alive on July 15, 1945.

Immediate cause of death Acute Lead Poisoning

Duration Appro[illegible] 15 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maybelle Weare

Address Provident Hosp Date signed 7/25/45 M. D.

VS 160

G31036

Dr Poulton 3909 Fairmount

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316 Registered No. G31036

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 S Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 S Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma M Jeffers

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Philip G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1882

8. AGE: Years 62 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name (Unknown) Gephart
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ruby G. Jeffers
(b) Address 39 S Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)
(c) Cemetery or crematory Westview
Location Baltimore Md

18 (a) Funeral director Pulliam & Cole
(b) Address 1217 W Pratt St

19 (a) Date rec'd July 26 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 6.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 25 1945, and that I last saw h[illegible] alive on July 24 1945.

Immediate cause of death Heart Failure — Duration —
Due to Myocarditis — Duration 6 mo
Due to Emphysema — Duration 1 year
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature V. E. Poulton
Address 3909 Fairmount Ave Date signed 7/28/45

VS 150

S. E. POULTON - X

G31037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E ✓ Registered No. G31037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1023 Penna. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace S. C.

16 (a) Informant Mrs Ethel Harris
(b) Address 531 W. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

JUL 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1945 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945 to July 23 1945 and that I last saw him alive on July 23 1945

Immediate cause of death: Myocarditis — Duration: 6 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Watts M. D.
Address 515 Eutaw Date signed 7/24/45

VS 150

X

G31038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G31038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 W. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL G. ADOLPHSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Adolphson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1889

8. AGE: Years 55 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Interior Decorator

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Don't Know

MOTHER
14. Maiden Name Don't Know
15. Birthplace Don't Know

16 (a) Informant Mrs Annie King
(b) Address 2510 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2118 Orleans St.

JUL 26 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1945, at 10 50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy
Marked hypertrophy + dilatation
of Ventricles.
Due to Probable Uremia,
Hypostatic Pneumonia
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 25 1945

G31039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1228

Registered No. G31039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 North Gay St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 North Gay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Nelson Eldridge Price

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm. W. Price
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) November 29-1859
8. AGE: Years 85 | Months 8 | Days 24 | If less than one day ... hr. ... min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Wm. Douglas Eldridge
13. Birthplace Mercer Co. New Jersey

MOTHER
14. Maiden Name Charlette J. Jamison
15. Birthplace New York City, New York

16 (a) Informant Addie Darling Price (Daughter)
(b) Address 1033 N. Gay Street Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 26 - 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. - City.

18 (a) Funeral director Stewart and Mowen Co.
(b) Address 108 West North Ave. Balto. Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar
JUL 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23rd 1945, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19th 1945 to July 23rd 1945 and that I last saw h[illegible] alive on July 23rd 1945.

Immediate cause of death	Duration
Intestinal obstruction	
Due to Cholecystitis	
Due to Osteosarcoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1005 St Paul St Date signed 7-25-45

G31040 JL - 94068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

Registered No. G31040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Whitlock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1903

8. AGE: Years	Months	Days	If less than one day
41 ?	11 10 ?	25 ?	hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Whitlock
13. Birthplace S. C.

MOTHER
14. Maiden Name Ella Daniels
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7-27-45 (month) (day) (year)
(c) Cemetery or crematory Chester, S. C
Location S. Carolina

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

JUL 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1945, to July 25 1945, and that I last saw h. im alive on July 25 1945

Immediate cause of death	Duration
Increased Intracranial Pressure	
Due to Tumor of Brain	4yrs?
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Jowell, M. D.
Address Balto. City Hosp. Date signed 7-25-45

VS-50

X

G31041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jr. Vernon Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/873

8. AGE: Years	Months	Days	If less than one day
72	1	16	hr. min.

9. Birthplace Frederick County Md.
(Town, county, and state)
10. Usual Occupation Handy Man
11. Industry or business

FATHER
12. Name Ezekiel Barnes
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Frederick Co, Md

16 (a) Informant James Barnes
(b) Address Westminster Co Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28/45 (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Cem.
Location Near Med Windsor Md.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster Md.

19 (a) JUL 26 1945 (Date rec'd by registrar) Huntington Nilliques M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 8.52 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945 to July 26 1945, and that I last saw him alive on July 26 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Cardiac vasc. heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry W. Camp M. D.
Address Mercy Hosp. Date signed 7/26/45

VS 150

G31042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31042 / 137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Oliver & Caroline Sts.

(c) Hospital or institution: St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 902 N. Lexington St apt 1

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME JAMES W. GARRETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: Color

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agnes Garrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/27/75

8. AGE: Years 70 yrs | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Agnes Garrett

(b) Address 902 N. Lexington St apt 1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Greenmount Memorial

Location Baltimore Md

18 (a) Funeral director Sam'l H. Chase Sons

(b) Address 638 N. Gilmor St

19 (a) JUL 26 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 1945, at 8 o'clock AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1945 to 7/23 1945 and that I last saw him alive on 7/23 1945

Immediate cause of death	Duration
Respiratory Failure.	
Due to Uremia.	
Due to Chronic Nephritis	
Other Conditions Basilar Hypostatic Pneumonia (Include pregnancy within 3 months of death)	

Date of operation 7/19/45

Major findings of operation: Supra Pubic Prostectomy (1st stage)

of autopsy: Chronic Nephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Everett M. D.

Address St. Joseph's Hosp. Date signed 7/23/45

VS 180

G31043 Clyde

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G31043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 E Eager St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Ornec

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophia Ornec

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Vincent Ornec
13. Birthplace Bohemia

MOTHER
14. Maiden Name Sophia Belohlavek
15. Birthplace Bohemia

16 (a) Informant Sophia Ornec
(b) Address 2324 E. Eager St

17 (a) Holy Redeemer (Burial, cremation, or removal) (b) Date thereof 7-26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Hugh Engelhart
(b) Address 2004 Chester St

JUL 26 1945 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943, to July 24 1945, and that I last saw h— alive on July 22 1945.

	Duration
Immediate cause of death Chronic Myocarditis	5 yrs
Due to Chronic Diabetes Mellitus	10 yrs
Due to Chronic Nephritis	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 2005 E. Monument St Date signed 7/25/45

VS 190

G31044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Morton Brundick

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred T. Brundick
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 26, 1895

8. AGE: Years	Months	Days	If less than one day
49	11	28	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Fire Dept.
11. Industry or business

FATHER
12. Name Henry Brundick
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizebeth Henning
15. Birthplace Baltimore Md.

16 (a) Informant Mildred T. Brundick
(b) Address 822 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Rd.

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) JUL 26 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 8 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1943, to July 24 1945, and that I last saw him alive on July 24 1945.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Coronary Seleiosis	1-16-43
Due to Coronary occlusion	7-24-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E A Schimunek M. D.
Address 1721 E Eager Date signed 7-25-45

SCHIMUNEK X

VS 180

G31045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

G31045 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4808 Gwynn-Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Gwynn-Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emeline J. Conner

3 (b) If veteran, name war: ---
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife: Capt. Henry F. Conner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1848

8. AGE: Years 96 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace Key-West Florida (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Mrs. Idabel C. Turner
(b) Address 4808 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) July 26 1945 (b) Registered by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1945 to July 25 1945, and that I last saw her alive on July 23, 1945.

	Duration
Immediate cause of death: Myocarditis	3 wks.
Due to: Advanced arteriosclerosis	?
Due to: Cystitis	1 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter F. Dieldt M. D.
Address 2220 Garrison Blvd Date signed 7/26/45

VS 150

G31046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 S. Conkling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Naimaster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Katie Serati
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1870

8. AGE: Years	Months	Days	If less than one day
74	7	-	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Naimaster
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Sarah Gatner
15. Birthplace Baltimore Co. Md.

16 (a) Informant Wife
(b) Address 1100 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Stemmers Run Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 JUL 26 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945 19 , at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to July 24 1945, and that I last saw him alive on July 24 1945.

Immediate cause of death: Arteriosclerotic C.V. Disease — Duration 6-15-43
Chr. Myocarditis
Due to Carcinoma of Cecum — 10-20-44
Decompensated Failure — 7-1-45
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed Schumacher M. D.
Address 842 E Eutaw Date signed 7-25-45

VS 150

SCHUMACHER X

G31047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31047 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW JACKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Charles M.
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Agnes Barker
15. Birthplace Baltimore

16 (a) Informant Sister
(b) Address 122 S. East Ave.

17 (a) Burial (b) Date thereof 7/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) JUL 26 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25/45 19 , at 1:05 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 7/25/45

VS 151

G31048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31048

Dowrny 467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fureden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Perryville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Dowrny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/30/1876

8. AGE: Years	Months	Days	If less than one day
69	2	26	hr. min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. A Abramathy

(b) Address Cherry Hill Cecil Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 1945 (month) (day) (year)

(c) Cemetery or crematory Lewisville Cem

Location Cecil Co. Md.

18 (a) Funeral director H. S. Bailey

(b) Address Darlington Md

19 (a) July 28 1945 (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1945, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1945 to 7-26 1945, and that I last saw him alive on 7-26 1945.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to Coronary Thrombosis	
Due to	
Other Conditions Carcinoma of rectum Ca metastasis (Include pregnancy within 3 months of death)	

Date of operation 7-23

Major findings of operation: Generalized Ca metastasis in abdomen

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald E Crouse MD

Address Maryland General Hosp Date signed 7/26 M. D.

VS 150

X

G31049

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G31049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University of Md. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph L Stockman
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/23/1876

8. AGE: Years	Months	Days	If less than one day
68	9	2	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business Balto Transit Co.

FATHER
12. Name Charles Stockmen
13. Birthplace Md

MOTHER
14. Maiden Name Wilhemina V.
15. Birthplace Md.

16 (a) Informant Mrs Mary Stockman
(b) Address 5718 Harford Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.
18 (a) Funeral director R. J. Kuck
(b) Address 5305 Harford Rd
19 (a) (Date received by local registrar) (b) Registrar

JUL 26 1945 Huntington Millemann, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 11:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to July 26 1945 and that I last saw him alive on July 26 1945

Immediate cause of death	Duration
Acute pulmonary edema	
Due to arteriosclerotic cardiovascular disease	
Due to	
Other Conditions Possible tuberculosis of lung (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation: none
of autopsy: not done

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P Quigg M. D.
Address University Hospital Date signed July 26 1945

G31050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G31050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Providents Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1347 W North ave

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Marie Kennard

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	N	married

6 (b) Name of husband or wife Charles Kennard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-05

8. AGE: Years	Months	Days	If less than one day
40 39	7 m 5	15	hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business none

FATHER

12. Name Samuel Tyler

13. Birthplace Md.

MOTHER

14. Maiden Name Mamie Cook

15. Birthplace ?

16 (a) Informant Husband

(b) Address 1347 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-45 (month) (day) (year)

(c) Cemetery or crematory Browns Chapel

Location Howard Co. Md

18 (a) Funeral director Robert E. Snowden

(b) Address Rockville MD. MaCo.

JUL 26 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-45 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1945 to 7-24 1945, and that I last saw her alive on 7-24 1945

Immediate cause of death: Toxemia

Due to: Glutial abscess

Due to:

Other Conditions: Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation 7-10-45

Major findings of operation: Glutial abscess

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J L Whitte M. D.

Address Provident Hospital Date signed 7-22-45

X

G31051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G31051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Smith Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Lee St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard E. Waidner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1872

8. AGE: Years	Months	Days	If less than one day
73	4	14	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Candy Merchant

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name M
15. Birthplace

16 (a) Informant Mr. Fred Waidner
(b) Address 210 E. Cross St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave.

18 (a) Funeral director Fred A. Thomas & Son
(b) Address 1216 N. Charles St.

19 (a) JUL 26 1945 (Date received by Local Registrar) Clarington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 10 53 M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fraley M.D. Medical Examiner.
Date signed July 26 1945

VS 151

G31052

BALTIMORE CITY HEALTH DEPARTMENT G31052
CERTIFICATE OF DEATH 1945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St Josephs Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3322 Emley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Connors

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married, widowed~~, or divorced. Widow

6 (b) Name of husband or wife Leo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16 1892

8. AGE: Years 52 | Months 8 | Days 9 | If less than one day hr. min. 18

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name John T. Lenkin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Johanna Michel
15. Birthplace Baltimore Md

16 (a) Informant Mrs J. M. Lenkin
(b) Address 415 N Bollington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 28 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Mosan
(b) Address 3000 E Baltimore St

19 (a) 26 1945 (Date rec'd by registrar) (b) Registrar
Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25 1945, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1945, to 7-25 1945, and that I last saw h-- alive on 7-25 1945.

Immediate cause of death — Duration
Cerebral Vascular accident
Due to Hypertensive CVD
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M E Robertson
Address St. Josephs Hosp M. D.
Date signed 7-25-45

M. D. B. 1208-6

G31053 HEALTH DEPARTMENT—CITY OF BALTIMORE G31053

CERTIFICATE OF DEATH V 110 B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217-E. Preston St. 10-1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 3 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Walter Edward Aytes

(a) Residence: No. 1217-E. Preston St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: Col.

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jeanette Aytes

6. DATE OF BIRTH (month, day, year): May 8-1874

7. AGE: Years 71 | Months 1 | Days 18 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Laborer - Retired Postal Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Va

FATHER

13. NAME: Cade Aytes

14. BIRTHPLACE (city or town) (State or country): Va

MOTHER

15. MAIDEN NAME: Mary Brown

16. BIRTHPLACE (city or town) (State or country): Va

17. INFORMANT (Address): Jeanette Aytes 1217 E. Preston St

18. BURIAL, CREMATION, OR REMOVAL Place: New York, N.Y. Date: 7/29 19 45

19. UNDERTAKER (Address): Joseph B. Lord Inc. 1304 N. Eutaw St

20. FILED JUL 26 1945 19 Huntington Williams, Mgr. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 7-26-45

22. I HEREBY CERTIFY, That I attended deceased from 2/27 19 45 to 7-26 19 45

I last saw him alive on 7-26-45 19 45 Death is said to have occurred on the date stated above, at 8:15 P.M.

The principal cause of death and related causes of importance were as follows:

(a) Coronary (thrombosis) (non T.B.) Hepatitis and Arteriosclerosis — Interval between onset and death

Other contributory causes of importance: Nephritis and Arteriosclerosis of 5 month duration

Name of operation: Signs + Symptoms Date of

What best confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) James R. Baker M. D.

(Address) 327-N. Central

7-26-45

X

V. S. 3

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G31054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G31054
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1730 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Reinhard

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widow

6 (b) Name of husband or wife Anna L. Reinhard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	25	h. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Reinhard
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dittus
15. Birthplace Germany

16 (a) Informant Mrs. Augusta Davis (Daughter)
(b) Address 1202 S. Clinton St.

17 (a) Burial (b) Date thereof 7-27-45,
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director L. Hellmann & Son
(b) Address 32 S. Broadway

1945 (b) [illegible] Huntington Williams, Registrar
Date rec'd by reg...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 6 1945 to July 24 1945, and that I last saw h[illegible] alive on July 24 1945.

Immediate cause of death	Duration
Apoplexy	
Due to Cancer of Rectum	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anna L. Reinhard
Address 3524 Greenmount Date signed 7/27/45 D.

G31055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Avondale Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Avondale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Wenzel

3 (b)-If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W. White	Widowed

6 (b) Name of husband or wife Maude (Unknown)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1877

8. AGE: Years	Months	Days	If less than one day
68	0	18	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business (Retired Broker)

FATHER
12. Name Geo. Wenzel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Kibler
15. Birthplace Germany

16 (a) Informant Schmidt Mrs. Katherine Schmidt
(b) Address 3402 Avondale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Forney Hyena
(b) Address 5005 Park Heights Ave

(c) Received by registrar Huntington Williams, M.D. registrar

JUL 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 8:A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 25 1945 and that I last saw him alive on July 23 1945.

Immediate cause of death Coronary occlusion
Congestive heart failure
Due to Coronary sclerosis
Due to General arteriosclerosis

Duration
2 days
7 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman R. Evans M. D.
Address 2601 Manhattan Ave Date signed 7-27-45

G31056 30+104

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31056
Registered No.

CERTIFICATE OF DEATH 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Pressard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B Jenny
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-11-23
8. AGE: Years 22 | Months 6 | Days 15 | If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Aubrey Jenny
13. Birthplace Va.
MOTHER 14. Maiden Name Annie
15. Birthplace Va.

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Balto. County Md.
18 (a) Funeral director Mrs. Robert A. Ellison
(b) Address 1129 N. Caroline St.
19 (a) Filed July 29 1945 (b) Registrar Huntington Williams registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945 at 10:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to July 26 1945 and that I last saw deceased alive on July 26 1945

Immediate cause of death
Due to Respiratory Failure
Due to Acute myeloid Leukemia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Addison J. Dixon
Address Johns Hopkins Hospital (Date signed) 7/29/45

VS 150

X

631057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James A Johnston

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29 1884

8. AGE: Years	Months	Days	If less than one day
60	8	29	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Richard Johnston
13. Birthplace N.C.

MOTHER
14. Maiden Name Adelaid michael
15. Birthplace N.C.

16 (a) Informant D. W. Babylon
(b) Address New Windsor Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1945 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster Maryland

18 (a) Funeral director D. D. Hoffa & Son
(b) Address New Windsor Md

19 (a) JUL 27 1945 (Date received by Registrar) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1945, at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945, to 7/27 1945, and that I last saw h~~im~~ alive on 7/26 1945 10 AM

Immediate cause of death Congestive Heart Failure - on Pulmonary Edema

Due to Chronic Emphysema

Due to

Other Conditions Cerebral embolism with right sided hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 weeks
3 yrs
8 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. T. Kundsen M. D.
Address University Hospital Date signed 7/29/45

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G31058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G31058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar James Haas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-45

8. AGE: Years | Months: 6 | Days: 22 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Geo. Haas
13. Birthplace Md.

MOTHER 14. Maiden Name Esse G. Baker
15. Birthplace Mount Airy Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Rd & Yorkshire

18 (a) Funeral director C. K. Conkling & Son
(b) Address 924 E. Eager St.

19 JUL 27 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1945 to July 26 1945 and that I last saw him alive on July 26 1945

Immediate cause of death: Septicemia — Duration: 9 days

Due to: Streptococcus and a Coliform organism

Due to:

Other Conditions: Aspiration pneumonia, diarrhea, thrombophlebitis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson, Assistant Resident M. D.
Address Date signed

VS 150

X

G31059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12a

Registered No. G31059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 E. 23rd St
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 E. 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/1893

8. AGE: Years	Months	Days	If less than one day
52	5	-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joe Moore
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Morton
15. Birthplace Va.

16 (a) Informant Florence Moore
(b) Address 306 E. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 28 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R.I. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 JUL 27 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-45 19 . at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7-45 19 . to 7-24-45 19 , and that I last saw h/M alive on 7-24-45 19 .

Immediate cause of death Hypertensive Cardio Renal Disease — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Avery Adams, M. D.
Address 312 E 23rd St Date signed 7-25-45

VS 150

X

G31060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Sapp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Sapp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captoria Carrie Giles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/6/1885

8. AGE: Years 60 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John Wrench
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Charles T. Chapman
(b) Address 1915 Sapp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B.R. Co

18 (a) Funeral director Raymon Sanders
(b) Address 1412 E. Preston St

19 (Date received by registrar) JUL 27 1945 Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-45 19 , at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-45 19 , to 7-24-45 19 , and that I last saw h alive on 7-23-45 19

Immediate cause of death Congestive Heart failure — Duration 3 Days

Due to Chr. Myocarditis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 312 E 23rd Date signed 7-25-45

VS 2

X

G31061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G31061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard M. Obringer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Obringer
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Apr 13 1888

8. AGE: Years	Months	Days	If less than one day
57	3	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Obringer
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Babkow
15. Birthplace Germany

16 (a) Informant Anna Obringer
(b) Address 719 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 30 (month) (day) (year)
(c) Cemetery or crematory Catholic Cem
Location Catonsville

18 (a) Funeral director Ellis Funeral Home
(b) Address 2008 Eutaw St

19 (a) JUL 27 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 1945 to 7-18 1945.
and that I last saw h alive on 7-18 1945.

Immediate cause of death Toxaemia from Carcinoma of the Bowel — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur W. Kaufman M. D.
Address 3862 Dolfield Ave Date signed 7-26-45

VS 150

G31062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ Registered No. G31062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 BANK ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 → 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 BANK ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BEYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY BEYER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 21 1894

8. AGE: Years	Months	Days	If less than one day
51	4 5	5	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name JOHN BEYER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARY SCHROLL
15. Birthplace BALTO. MD.

16 (a) Informant MARY BEYER (WIFE)
(b) Address 1828 BANK ST.

17 (a) BURIAL (b) Date thereof JULY 30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Geiler inc.
(b) Address 403 S. MOLFE ST.

19 JUL 27 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 26 1945, at 2/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945 to July 26 1945, and that I last saw him alive on July 26 1945.

	Duration
Immediate cause of death: Acute Coronary Thrombosis	4 days
Due to: Coronary Sclerosis and Angina Pectoris	10 mos.
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest J. Lattof M. D.
Address 2001 E. Lafayette Date signed 7/27/45

VS 150

G31063 STRAUGHAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G31063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution:
Univ. of Md. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Lexington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lulu Straughan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	married

6 (b) Name of husband or wife Fredrick Straughan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3/4/1878

8. AGE: Years	Months	Days	If less than one day
67	4	20	hr. min.

9. Birthplace Willenbaney Pa
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business Home

FATHER
12. Name William Charles Sherwood
13. Birthplace Pa

MOTHER
14. Maiden Name Alice Thornton
15. Birthplace Pa

16 (a) Informant Ruth Ray
(b) Address 727 Lexington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Filed JUL 27 1945 (b) Signature of registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26 1945, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945 to July 26 1945, and that I last saw her alive on July 26, 1945

Immediate cause of death	Duration
Pulmonary embolism	
Due to Coronary occlusion	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Roy H. Ott, Jr. M. D.
Address Univ. Hosp Date signed 7/26/45

VS 150

94a

G31064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G31064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur J Winder

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1896

8. AGE: Years	Months	Days	If less than one day
48 49	11	10	hr. min.

9. Birthplace Baltimore, Md. (town, county and state)
10. Usual Occupation Butler
11. Industry or business

FATHER
12. Name Arthur Snyder
13. Birthplace Virginia

MOTHER
14. Maiden Name Millie Barnes
15. Birthplace Cambridge, Md.

16 (a) Informant Mrs. Millie Barnes
(b) Address 1827 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Balto. Md.

18 (a) Funeral director Chas. George A. Holland
(b) Address 1631 Druid Hill Ave

19 JUL 27 1945 (Date received by Local Registrar) (b) Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 11 PM

21. I certify that I last saw ~~in charge~~ of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gunter M.D.
Medical Examiner.
Date signed July 24 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 N Calhoun St

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Washington

(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph Kreutz

3 (b) If veteran, name war unknown

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1892

8. AGE: Years 53 | Months 3 | Days | If less than one day hr. min.

9. Birthplace unknown
(Town, county, and state)

10. Usual Occupation none

11. Industry or business unknown

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Franklin Sq. Hosp.

(b) Address Fayette & Calhoun Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Georgia Ave & Pleasant Hill Road

18 (a) Funeral director John D. Fahey & Sons

(b) Address 13 E Eager St

19 (a) Date received by local registrar JUL 27 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945, to July 24 1945, and that I last saw him alive on July 23 1945.

Immediate cause of death	Duration
cardiac failure	
Due to bronchopneumonia	
Due to subarachnoid hemorrhage	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Cerebral hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence July 13 1945 at 2 P.M.

(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? on street While at work?
(Specify type of place)

(e) Means of injury fell down stairs at home

23. Signature Huntington Williams M. D.

Address Franklin Square Hospital Date signed 7/24/45

G31066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31066

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.D.K.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie August

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 29 1867

8. AGE: Years 66 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Westmoreland Co., Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gas Branson.
13. Birthplace Westmoreland Co. Va.

MOTHER 14. Maiden Name Lizzie Coleman.
15. Birthplace Westmoreland Co. Va.

16 (a) Informant Ethel Parker.
(b) Address 1944 Lanetta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Auburn.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) JUL 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1945, at 10:35 P M

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. C. Pulaski M.D. Medical Examiner.
Date signed 7-24-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G31067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Frankford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Frankford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** A. Marshall Greif

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/34

8. AGE: Years	Months	Days	If less than one day
11	9	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Albert C Greif
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name A. Ethel Schamb
15. Birthplace Balto. Md.

16 (a) Informant A.C. Greif
(b) Address 2604 Frankford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 28 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral directors Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) JUL 27 1945 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1945, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 7-26 1945 and that I last saw h[illegible] alive on 7-24 1945.

Immediate cause of death	Duration
Carcinoma nasopharynx (Fibro sarcoma)	1 yr 9 mo
Due to ?	
Due to	
Other Conditions Bronchopneumonia (Include pregnancy within 3 months of death)	

Date of operation 6-7-44 & 1-15-45
Major findings of operation Tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature Fred T. Kyser M. D.
Address Medical Arts Bldg. Date signed 7-27-45

VS 150

X

G31068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G31068 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Hoffman Sts

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 117 Belmar Ave.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/26/45

8. AGE: Years	Months	Days	If less than one day
			3 hr. 90 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER

12. Name Eugene L. Young

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Katharine Latrue Walkling

15. Birthplace Westminster, Md.

16 (a) Informant Katharine Young

(b) Address mother

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 740 Belair Rd.

19 JUL 27 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 26 1945, and that I last saw h i M alive on July 26 1945.

Immediate cause of death Prematurity — Duration

Due to Premature Labor

Due to

Other Conditions Cord around the neck three times
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. [illegible] M.D.

Address 1[illegible] N. Caroline St Date signed 7-27-45

VS 180

G31069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G31069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Ann St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hofstetter

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1881

8. AGE: Years 83 | Months 8 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Adam Trabandt
13. Birthplace Germany

MOTHER
14. Maiden Name Christina ?
15. Birthplace Germany

16 (a) Informant Joseph Hofstetter
(b) Address 33 S. Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East of North Ave.

18 (a) Funeral director W. W. E. Dippel & Sons
(b) Address 1201 East Lord Baltimore St.

19 (a) 1111 27 1945 Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7-1945 to 7-25-1945 and that I last saw h[illegible] alive on 7-25-1945.

Immediate cause of death Subarachnoid Hemorrhage.

Due to Rupture left middle cerebral artery

Due to Hyp. & Arter. H. D.

Other Conditions Possible Metastatic carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp Date signed 7-25-45

937

VS 150

G31070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registration No. G31070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d.
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME William Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Deceased
(c) If alive, give age years
Anna Bahnlow

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Tavern owner
11. Industry or business own business

FATHER
12. Name Do not Know
13. Birthplace " " " "

MOTHER
14. Maiden Name Do not Know
15. Birthplace " " " "

16 (a) Informant Miss Mary Russell
(b) Address 1542 Hanover

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Highway

18 (a) Funeral director J. J. Daley Sons
(b) Address 31 Light St

19 JUL 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1945, at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1945 to 7-26 1945 and that I last saw him alive on 7-26 1945.

Immediate cause of death Heart failure — Duration
Due to Hypertensive C-V disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger, M.D.
Address 1213 Light St Date signed 7-26-45

VS 150

X ARDINGER

G31071 CAGle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133 B

Registered No. G31071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 | 8
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 853 W. Lombard St. - 2 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Effie Cagle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Walter Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1891

8. AGE: Years	Months	Days	If less than one day
54	1	26	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name John Ludwig
13. Birthplace N. C.

MOTHER
14. Maiden Name Julia Cobb
15. Birthplace N. C.

16 (a) Informant MRS Grace Oates
(b) Address 853 W. LOMBARD ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-45 (month) (day) (year)

(c) Cemetery or crematory Concord
Location Kremmapolis N. C.

18 (a) Funeral director Frederick S. Poff
(b) Address 1203 W. Lombard St

19 (a) Date received JUL 27 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 | 26 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 | 26 1945 to 7 | 26 1945, and that I last saw h[illegible] alive on 7 | 26 1945.

Immediate cause of death	Duration
Gas gangrene infection, probably blood stream, 2 days	
Due to in L kidney resulting in acute renal failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7 | 26 | 45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sarah Cobb M. D.
Address Univ. Hosp. Date signed 7 | 26 | 45

VS 150

G31072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31072 Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 1 Light Street
(c) Hospital or institution South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 163 North Curley (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ROBERT LAWSON SR.

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-05-6164

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): June 1, 1889

8. AGE: Years: 56 | Months: 1 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Marine Fireman

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Bennett R. Lawson
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Margaret Stockman
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary Lawson
(b) Address: 163 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory: 1st Evangelical
Location: Baltimore City

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway, Huntington for Hollander, Md.

19 (a) JUL 27 1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26/45 19..., at 7 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Waters M.D. Medical Examiner
Date signed 7/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31973 46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G31073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 E. Biddle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Nelson Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Defense work

11. Industry or business

FATHER 12. Name Louis Coleman

13. Birthplace Maryland

MOTHER 14. Maiden Name Rachel Demby

15. Birthplace Maryland

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County Md.

18 (a) Funeral director Joseph B. Lake.

(b) Address 1300 Central Ave Penning for Williams, Md.

19 (a) 7-27-1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25-1945 to 7-25-1945 and that I last saw her alive on 7-25-1945.

Immediate cause of death Acute pan-creatitis

Due to Cholelithiasis

Due to

Other Conditions Cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Acute hemorrhagic pancreatitis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph H. Kieffer M.D.

Address Johns Hopkins Hosp. Date signed 7-26-45

X - KIEFFER-51

G31074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G31074

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 S. Curley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 737 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Koglakowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife Walter Koglakowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 1, 1899

8. AGE Years	Months	Days	If less than one day
46 ST.	6	25	hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name FELIKS CHmiel
13. Birthplace POLAND

MOTHER
14. Maiden Name MARY KOZEK
15. Birthplace POLAND

16 (a) Informant MR. WALTER KOZLAKOWSKI
(b) Address 737 S. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) Date received by local registrar JUL 27 1945 (b) Signature Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 - 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of pancreas.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D. Medical Examiner.
Date signed 7-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G31075 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 W. Balto. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Bertha Classen (KLASSEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 13 1887

8. AGE: Years	Months	Days	If less than one day
57	9	14	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation SALES LADY.

11. Industry or business —

FATHER
12. Name ADOLPH KLASSEN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH FERSCH.
15. Birthplace BALTO MD

16 (a) Informant MARGARET KLASSEN
(b) Address 2107 W BALTO. ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof JULY. 30-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A. A. Co.

18 (a) Funeral director Bernard C. Hartke
(b) Address 121 E West St

19 (a) Date received JUL 27 1945 (b) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1945, at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1945 to 7-27 1945 and that I last saw h.r alive on 7-27 1945

Immediate cause of death Left Lobar Pneumonia — Duration

Due to Malnutrition Dehydration

Due to Pernicious Anemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Kalcff Jr. M.D. M. D.
Address St. Agnes Hosp Date signed 7/27/45

X RATLIFF

G31076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31076 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~1811 Hayford Ave.~~ 9

(c) Hospital or institution:

St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore City

(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1811 Hayford Ave. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME John Zimmerman John W. Zimmerman

3 (b) If veteran, name war None

3 (c) Social Security Account No. 579-09-4080

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Lillian Koellem

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Apr. 14 1877

8. AGE: Years	Months	Days	If less than one day
67	8	12	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Mens Hats

FATHER 12. Name William Zimmerman

13. Birthplace Germany.

MOTHER 14. Maiden Name Krukenberg.

15. Birthplace Hannover.

16 (a) Informant Mrs. Lillian C. Zimmerman

(b) Address 157 Sanford Ave New York City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director George J. Ruth Inc.

(b) Address 1725 Hanford Ave

19 (a) [illegible] (b) [illegible]

(Local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to July 26 1945, and that I last saw him alive on July 26, 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William A. Hodgen M. D.

Address St. Joseph's Hosp. Date signed 7/[illegible]/45

X

G31077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G31077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Allen

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kathryn T. Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1879

8. AGE: Years	Months	Days	If less than one day
65	11	6	hr. min.

9. Birthplace Seaford, Del.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown, Cork & Seal Co.

FATHER
12. Name Robert J. Allen
13. Birthplace Seaford, Del.

MOTHER
14. Maiden Name Esther Lloyd
15. Birthplace Del.

16 (a) Informant Mrs. Kathryn T. Allen
(b) Address 2802 Roslyn Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory
Location Seaford, Del.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed 7 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 28 1945 and that I last saw h[illegible] alive on July 26 1945

Immediate cause of death Generalized thrombo-phlebitis — Duration 3 1/2 mo.

Due to Ruptured appendix & generalized peritonitis — 1 wk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ruptured appendix & gen. peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Cordell M. D.
Address Md. Gen. Hosp., Balto. Md. Date signed 7-27-45

VS 150

X

G31078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2747 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2747 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY WOLTERS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Lucille K. Wolters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1893

8. AGE: Years	Months	Days	If less than one day
52	2	26	hr. min.

9. Birthplace Bath, N. Y.
(Town, county, and state)
10. Usual Occupation Cab Driver
11. Industry or business Sun Cab Co.

FATHER
12. Name -- Wolters
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Lucille K. Wolters
(b) Address 2747 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 25, 1945, at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945 to July 25 1945 and that I last saw h[illegible] alive on July 25 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1½ hr.
Due to Coronary Thrombosis	10 wk.
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Adelman M. D.
Address 12 01 Lydia Street Date signed 7-25-45

Ch. Chester J. Lubanski per, Approved. Robert L. Bratton M.D.

VS 150

G31079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G31079
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Howard Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth F Buck

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Rita F Buck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1896

8. AGE: Years	Months	Days	If less than one day
49	5	27	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Production Eng.
11. Industry or business Standard Gas Equip.

FATHER
12. Name George Buck
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Harriett Fergusson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rita F. Buck
(b) Address 3401 Fairview Ave. 16

17 (a) Burial (b) Date thereof 7/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 27 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1945 to July 25 1945 and that I last saw h.. alive on July 24 1945

Immediate cause of death	Duration
peripheral Vascular Collapse	10 days
Due to Carcinoma of Lung	
Due to	
Other Conditions Metastatic Ca. To Spine	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Md. Gen'l. Hosp. Date signed 7/25/45

VS 150

G31080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31080 Registered No. 91a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 East 32nd. St.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Grace E. Schnabel

3 (b) If veteran, name war -

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William C. Schnabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22nd. 1885

8. AGE: Years 60 | Months 5 | Days 4 | If less than one day 1 hr. 45 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Wife

11. Industry or business

FATHER 12. Name Thomas Stone.
13. Birthplace London, Eng.

MOTHER 14. Maiden Name Moriah Endesbeck
15. Birthplace London, Eng.

16 (a) Informant Mrs. C.A. Dougherty (Daughter)
(b) Address 4325 Hartford Road - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar 7-31-1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945, at - M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15th 1945, to July 27 1945, and that I last saw her alive on July 26th 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Subacute Bacterial Endocarditis	37 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 7/27/45 M. D.

VS 130

X

G31081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G31081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town) 13
(d) Street No. 2102 W North Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T. Fowler

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Lydia M Fowler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 22, 1861

8. AGE: Years: 84 | Months: 0 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Retired Cutter

11. Industry or business: B.V.D. Corp.

FATHER
12. Name: Thomas Fowler
13. Birthplace: Md.

MOTHER
14. Maiden Name: -
15. Birthplace

16 (a) Informant: Mrs. Lydia M. Fowler
(b) Address: 2102 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar: 1945 (b) Registrar: Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26/1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1945, to 7-26 1945, and that I last saw alive on 7-26 1945.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Pneumonia	
Due to: Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Richard D Hoover M. D.
Address: Univ. Hosp. Date signed 7/26/45

VS 150

G31082
AB-94896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31082
Registered No. 307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2- 1897

8. AGE: Years	Months	Days	If less than one day
48	4	24	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Jones
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/31/45 (month) (day) (year)
(c) Cemetery or crematory
Location Washington blvd

18 (a) Funeral director Mrs Geo H Hallam d
(b) Address 163 (Dunbar Hill av.

19 (a) 7-27-1945 (Date registered) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26- 1945, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1945, to 7-26 1945, and that I last saw h im alive on 7-26 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to cardiac failure	
Due to Syphilitic cardio-vascular disease with aortic	
Other Conditions insufficiency and aortitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Syphilitic aortitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address [illegible] Date signed 7/27/45

G31083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31083 Registered No. 1170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 739 Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Field

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
19			hr. min.

9. Birthplace Winnsboro, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Sam Fields

FATHER — 13. Birthplace S. C. Winnsboro,

MOTHER — 14. Maiden Name Julia Goodwin

MOTHER — 15. Birthplace S. C.

16 (a) Informant Sam Fields

(b) Address Winnsboro, S. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)

(c) Cemetery or crematory

Location Winnsboro, S. C.

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Brantley Ave

19 (a) Date received (b) JUL 27 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric Hemorrhage

Due to Acute gastric ulcer

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed July 27 1945

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G31084 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 S. Light St.
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs. Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA ROBERTS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph M. Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1877

8. AGE: Years 67 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Lionel Mich
13. Birthplace New Jersey

MOTHER
14. Maiden Name ? Don't know
15. Birthplace New Jersey

16 (a) Informant Mrs. Lewis Benson (daughter)
(b) Address 1631 Carlsson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. a 6

18 (a) Funeral director C. H. Girard Evans
(b) Address 1400 Pennsylvania Ave Washington, D.C.

19 (a) 7-27-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to July 26 1945; and that I last saw her alive on July 26 1945.

Immediate cause of death: Pneumonia — Duration 1 day

Due to — Duration

Due to — Duration over

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Arduengo M.D.
Address 1213 Light St Date signed 7-26-45

VS 150

G31085 ✓ G31085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 766 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 766 Carroll St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar L. Gunther

3 (b) If veteran, name war No
3 (c) Social Security Account No. 212-10-5680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Wilhelmina Gunther
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1886

8. AGE: Years	Months	Days	If less than one day
59	6	4	hr. min.

9. Birthplace Annapolis Md (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Standard Gas & Electric

FATHER
12. Name Max Gunther
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Balto Md

16 (a) Informant Wilhelmina Gunther
(b) Address 766 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Balto Co

18 (a) Funeral director P. Howard Evans
(b) Address 1400 N Charles St - Balto 39 Md

19 (a) JUL 27 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 14th 1945 to July 26 1945 and that I last saw h alive on July 26 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 years
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John J. Cate, M. D.
Address 517 Scott St. Date signed 7/27/45

X

G31086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G31086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3124 Cheeley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 Cheeley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine B. Senft

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John V. Senft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-1844

8. AGE: Years 61 | Months 6 | Days 7 | If less than one day hr. min. 84

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Charles Meyer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret
15. Birthplace Germany

16 (a) Informant Mrs. John V. Senft
(b) Address 3124 Cheeley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director A. R. Rusk
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Williams Registrar
(c) Date received by registrar 7-27-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1944 to July 25 1945, and that I last saw h[illegible] alive on July 24 1945

Immediate cause of death Myocardial failure — Duration 2 days
Due to Carcinoma breast — 2 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Barley M. D.
Cheeley Ave Baltimore
Date signed 7/26/45

631087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 631087 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Frankford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman E. Schulze

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Ella M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 - 1891

8. AGE: Years	Months	Days	If less than one day
53	10	6	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation watchman
11. Industry or business

FATHER
12. Name Frederick
13. Birthplace Germ

MOTHER
14. Maiden Name Marie Rose
15. Birthplace Germ

16 (a) Informant Ella M. Schulze
(b) Address 4-13 Frankford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto Md

18 (a) Funeral director Leonard Mertz
(b) Address 5-305 Hanford Rd

19 (a) JUL 27 1945 (Date received by Registrar) (b) Registrar M.R.
Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1945, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Lubenski M.D. (Medical Examiner.)
Date signed 7/27/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31088 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Akron
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.D #6 Box 408
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Schoblocker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1911

8. AGE: Years	Months	Days	If less than one day
34	4	10	hr. min.

9. Birthplace Yugloudlavia (Town, county, and state)

10. Usual Occupation Schaeffer

11. Industry or business

FATHER
12. Name Henry Schoblocker
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Hungary

16 (a) Informant Hummel Funeral Home
(b) Address Akron Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1945 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Cross
Location Akron Ohio

18 (a) Funeral director Leo J. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b)
(Date received by registrar) Registrar

7-28-1945
CVS 151-5 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive 4th degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/6

(a) Date of injury 7-27-45 at about 1 P.M.
(b) Where did injury occur? 2700 Block Wilkens Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Truck & Truck Collision

23. Signature Roland Lee Frahm M.D.
Medical Examiner.
Date signed July 27 1945

X

G31089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31089 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Fairmont (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Virginia Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grant Anderson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-12-84
8. AGE: Years 61 Months 6 Days 15 If less than one day hr. min.
9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Laborer for City
11. Industry or business
FATHER 12. Name George Anderson
13. Birthplace Pa
MOTHER 14. Maiden Name Dicie Gordon
15. Birthplace Pa
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) ~~Burial~~ / Removal (b) Date thereof 7-31-45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Fairmont, W. Va.
Location Rochester, Pa.
18 (a) Funeral director John A. Mitchell & Sons
(b) Address 19 W. Eastern Place Washington, Pa.
Filed 7-27-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945 at 10:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 27 1945 and that I last saw him alive on July 27 1945.

Immediate cause of death	Duration
Shock	
Due to Operative	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-13-45
Major findings of operation: Bronchogenic Carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R. F. Kurfman M.D.
Address John Hopkins Hosp. Date signed 7-31-45

VS 190

G31090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G31090

Registered No. 64287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Tampa (If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 25th (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Lindbergh Hearring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1927

8. AGE: Years	Months	Days	If less than one day
17	7	8	hr. min.

9. Birthplace Hillsborough, Florida (Town, county, and state)
10. Usual Occupation Utilityman
11. Industry or business Seafaring

FATHER
12. Name Frank Genoval Hearring
13. Birthplace Georgia

MOTHER
14. Maiden Name Orise Marei Bellerive
15. Birthplace Canada

16 (a) Informant Records - U. S. Marine Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Tampa, Fla.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

JUL 28 1945

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH July 26 1945, at 6:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945, to July 26 1945, and that I last saw him alive on July 26 1945.

Immediate cause of death	Duration
Fracture, dislocation fifth cervical vertebra	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-1-45 M
(c) Where did injury occur? Tampa Florida (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No.
(e) Means of injury Fire pinto shallow water

23. Signature John A. Wilson M. D.
Address U. S. Marine Hospital Date signed 7/27/45
Baltimore 11, Maryland.
Howard J. Madden M.D.

G31091

JS #92690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G31091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals 22

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 608 S. Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1866

8. AGE: Years	Months	Days	If less than one day
79	?	?	hr. min.

9. Birthplace Virginia ? (Town, county, and state)

10. Usual Occupation Unable to obtain information

11. Industry or business " " " "

FATHER

12. Name Nathan (d)

13. Birthplace Va.

MOTHER

14. Maiden Name Mary (d)

15. Birthplace Va.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 28 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1945, at 5:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21, 1945 to July 20, 1945, and that I last saw h im alive on July 19, 1945.

Immediate cause of death Respiratory failure

Due to cardiac failure

Due to pneumonia

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address 2 < H. Date signed 7/20/45

1866 Jonathan Howland X

G31092

JV - 94491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G31092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5 Exeter St (North) (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1873

8. AGE: Years 72 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Pierce

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Jennie Arthurs

MOTHER 15. Birthplace Pa.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 28 1945 (Date rec'd by registrar) (Signature) Washington Williams M.D.

VS 180

2869

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945, to July 14 1945, and that I last saw him alive on July 14 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Pneumonia	
Due to	over
Other Conditions cardiac failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jonathan Haviland M. D.

Address BEH Date signed 7/24/45

G31093

CWK-93967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31093

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 19

(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 523 N. Chapel Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Earnest Madden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1899

8. AGE: Years	Months	Days	If less than one day
46	0	0	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Coal Truck Driver

11. Industry or business Highland Coal Co.

FATHER

12. Name George Madden

13. Birthplace Virginia

MOTHER

14. Maiden Name Mary Becks

15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 JUL 28 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 19 1945, and that I last saw h im alive on July 19 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.

Address Balto. City Hosp. Date signed 7/29/45

F-2871

VS 150

G31094

CWK-16160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14- 9- 12
(e) Length of stay in Baltimore (yrs., mos., or days) 94- 4- 28

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 863 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21-1851

8. AGE: Years	Months	Days	If less than one day
94	4-	28	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Melvina Cruser
15. Birthplace New Jersey

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19- 1945, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1941, to July 19 1945, and that I last saw him alive on July 19 1945.

Immediate cause of death Respiratory failure — Duration

Due to heart failure

Due to Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Rhoads M. D.
Address B C H. Date signed 7/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2870

X

G31095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170 C

Registered No. G31095

correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland: Baltimore Md.
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Atteway (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorenzo Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eunice Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1914

8. AGE: Years	Months	Days	If less than one day
30	6	28	hr. min.

9. Birthplace Beaufort North Carolina (Town, county, and state)
10. Usual Occupation Laborer Boiler
11. Industry or business

FATHER
12. Name Coleman Lewis
13. Birthplace Beaufort North Carolina

MOTHER
14. Maiden Name Bang
15. Birthplace North Carolina

16 (a) Informant Unice Lewis
(b) Address North Carolina

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Beaufort North Carolina

18 (a) Funeral director D Lee Odom
(b) Address 4644 York Rd

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JUL 28 1945

VS 151

MEDICAL CERTIFICATION 12 15

20. DATE OF DEATH July 27, 45 19 , at P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Explosive 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20/6
(a) Date of injury 1:10 A. at 7-27-45 M.
(b) Where did injury occur? 2700 block Aiken avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Truck & truck collision

23. Signature Robert Lee Foster M.D. Medical Examiner.
Date signed July 27, 1945.

G31096

Eyrene # 12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G31096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Found in Harbor / Foot of William St
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 S. Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malachia Merritt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife: Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1900

8. AGE: Years	Months	Days	If less than one day
45	2		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wesley Merritt
13. Birthplace

MOTHER
14. Maiden Name Lula
15. Birthplace Virginia

16 (a) Informant Brenitta Merritt (Father)
(b) Address 919 Low St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
(d) Location

PUBLIC CEMETERY JUL 27 1945
Commissioner of Health

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St.

19 JUL 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1945 at 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-22-45 at 7:20 P. M. 24/4
(b) Where did injury occur? Harbor - Foot Williams Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Found drowning.

23. Signature Robert E. Gruber M.D. Medical Examiner.
Date signed July 23, 1945

VS 151 (OVER)

G31097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown Rd
(c) Hospital or institution: Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Chendell (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Jacqueline Janik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/26/45

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Middle River, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Fred Janik
13. Birthplace Chicago, Ill

MOTHER
14. Maiden Name Helen Spacek
15. Birthplace Cleveland, Ohio

16 (a) Informant Father
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 28 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1945 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1945 to 7/24 1945, and that I last saw her alive on 7/24 1945.

Immediate cause of death Diarrhoea

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mark M. D.
Address Univ Hosp Date signed 7/24/45

VS 180

2873

G31098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G31098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~948 Saratoga St~~
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Black

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-82

8. AGE: Years 63 | Months 6 5 | Days 11 23 | If less than one day hr. min.

9. Birthplace Orangeburg, S.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Thomas Black
13. Birthplace N.C

MOTHER
14. Maiden Name Nellie Miller
15. Birthplace S.C.

16 (a) Informant Wife
(b) Address 948 Saratoga St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 28 1945 (Date rec'd by registrar) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10 1945, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1945, to 7-10 1945, and that I last saw h[illegible] alive on 7-10 1945

Immediate cause of death: acidosis — Duration

Due to: diabetes

Due to:

Other Conditions: Urethral stricture
(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: Pyonephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Shubitz M. D.
Address Provident Hospital Date signed 7-2-45

VS 150

2872 X 45

G31099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 E. 30th St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 E. 30th St., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles F. Snow

3 (b) If veteran, name war --

3 (c) Social Security Account No. 215-07-0940

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary M. Snow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1888

8. AGE: Years 57 | Months 0 | Days 27 | If less than one day hr. min.

9. Birthplace Snow Hill, Md. (Town, county, and state)

10. Usual Occupation Clerk
11. Industry or Business Fairfield

FATHER
12. Name Charles F. Snow
13. Birthplace Snow Hill, Md.

MOTHER
14. Maiden Name Alice Vickers
15. Birthplace Snow Hill, Md.

16 (a) Informant Mrs. Mary M. Snow
(b) Address 1730 E. 30th St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JUL 28 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1945 at 7.45 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-15-1945 to 7-25-1945 and that I last saw him alive on 7-25-1945.

Immediate cause of death apoplexy — Duration 1 day
Due to arteriosclerosis — Duration unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Gilbert M. D.
Address 710 Harford Ave. Date signed 7-26-45

VS 150

631100 Dr Wilmer

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

631100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John's Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) 49 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Andrzej Henry Skalski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-0892

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Theresa Skalski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30 1887

8. AGE: Years	Months	Days	If less than one day
57 58	7	25	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Skalski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Koprowski
15. Birthplace Poland

16 (a) Informant Mrs. Theresa Skalski
(b) Address 503 S. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. County

18 (a) Funeral director John M. Wehrly
(b) Address 40 S. Chester Street

19 (a) JUL 28 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 /45 19 , at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from on July 25 1945, to 19 , and that I last saw him alive on July 24 1945.

Immediate cause of death	Duration
cardiac dilitation & failure	
Due to ? coronary thrombosis	
Due to	
Other Conditions widely metastasized lymphosarcoma (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham G. Wilmer M.D.
Address Johns Hopkins Hosp Date signed 7/27/45

VS 150 GRAHAM-VANCE approved by Thomas J. Mackell, M.D. X

G31101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G31101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Wyatte c Calhoun
(c) Hospital or institution: Franklin Square Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Hudson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Flather

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Sarah R
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23-1861

8. AGE: Years	Months	Days	If less than one day
84	11	3	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Penn. R.R.

FATHER
12. Name Edwin M Flather
13. Birthplace England

MOTHER
14. Maiden Name Eliza Evans
15. Birthplace Md.

16 (a) Informant Mrs Laura Belt
(b) Address 3623 Hudson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30-45 (month) (day) (year)
(c) Cemetery or crematory St Marys (Hampden
Location Baltimore Md

18 (a) Funeral director Frank H Belt
(b) Address 814 W 36 St

(a) (Registrar) (b) Huntington Williamsport, Md

AUG 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-26 1945, at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1945 to 7-26 1945, and that I last saw h alive on 7-26 1945.

Immediate cause of death	Duration
cachexia	
Due to carcinomatosis	
Due to carcinoma of prostate (??)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Kerzerian M. D.
Address 7 Franklin Square Hosp Date signed 7-26-45

G31102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G31102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 N. Wolfe
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Wolfe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Mickey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	M.

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12-1896

8. AGE: Years	Months	Days	If less than one day
49	4	13	14 hr. min.

9. Birthplace Rockland Co. Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Mickey
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Fife
15. Birthplace Va.

16 (a) Informant Louise Mickey
(b) Address 1037 Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-00-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co

18 (a) Funeral director Samuel W. Ehrhart Son
(b) Address 638 N. Gilmor St.

19 (a) (Date received by registrar) Huntington Williams, M.D.
JUL 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 8.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 26 1945 and that I last saw him alive on July 26 1945

Immediate cause of death Acute myocarditis
Pulmonary edema
Due to Cerebral apoplexy
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 day
20 days
1 mo.
—

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Berry M. D.
Address 420 E. Chase Date signed 7-28-45

X

VS-46

Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct age is especially important.

G31103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31103 Registered No. 137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Green Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Long Green, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Schmidt, George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-1862

8. AGE: Years	Months	Days	If less than one day
82	8	2	hr. min.

9. Birthplace Long Green, Md (Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business

FATHER
12. Name John Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Stmuller
15. Birthplace Germany

16 (a) Informant Miss Etta Schmidt
(b) Address Long Green

17 (a) Burial (Burial, cremation or removal) (b) Date thereof July 29 '45 (month) (day) (year)
(c) Cemetery or crematory St Johns Bleheim
Location

18 (a) Funeral director A. R. Slyde
(b) Address 4907 York Road

19 (a) (Signature of registrar) (b) JUL 28 1945 Registered Huntington Valley, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20/45 1945, to 7/25 1945, and that I last saw him alive on 7/25 1945.

Immediate cause of death	Respiratory Failure	
Due to	Pneumonia, Prostatectomy for Benign Prostatic Hypertrophy	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 6/25/45

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James G. Bowers, M.D.
Address Upperco, Md. Date signed 7/26/45

G31104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G31104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Battery Ave
(c) Hospital or institution: 24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Battery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva M. Eichhorn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Wilhelm
6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1864

8. AGE: Years	Months	Days	If less than one day
80	10	25	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Adam Adolph Seifert
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna Papp.
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1438 Battery Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross.
Location Brooklyn, Md.

18 (a) Funeral director James L. McCauley & Son
(b) Address 60 S. Fort Ave.

19 JUL 28 1945 (Date rec'd by registrar) Submitted for William M. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to July 27 1945. and that I last saw her alive on July 27 1945

Immediate cause of death	Duration
Myocardial insufficiency	1 wk.
Due to Carcinoma of liver	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Feezer M. D.
Address 1802 Eastern Date signed 7-28-45

VS 150

X

1105
497071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered 681105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Dannenberg.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-05

8. AGE: Years	Months	Days	If less than one day
40	3	27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Hospital Orderly.
11. Industry or business

FATHER
12. Name Harry Dannenberg.
13. Birthplace Md.

MOTHER
14. Maiden Name Effie Bittler
15. Birthplace Md.

16 (a) Informant Friend.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Harry E. Coutz Co.
(b) Address Frederick, Md.

19 JUL 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 3.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to July 28 1945, and that I last saw him alive on July 28 1945.

Immediate cause of death Hodgkins Disease — Duration 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham G. Wade M.D.
Address Johns Hopkins Hosp. Date signed 7/28/45

VS 150

31106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 631106

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Penna Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Penna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bessie Greenwell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Jessie Greenwell
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 10 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
57	2	16		

9. Birthplace St Marys Co Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Richard Fredrick
13. Birthplace St Marys Co Md

MOTHER
14. Maiden Name Rachel Watts
15. Birthplace St Marys Co Md

16 (a) Informant William Mason
(b) Address 819 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Mt. Auburn

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 222 N. Schroeder St.

19 (Date rec'd by registrar) JUL 28 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-17 1945 to 7-26 1945 and that I last saw h[illegible] alive on 7-24 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	1 yr
Due to	
Other Conditions Gastritis Ulcer Stomach	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Atwell Jones M.D.
Address 535 Dolphin St Date signed 7-26-45

G31107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G31107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2840 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine K. Bergin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Dennis Lee Bergin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 65	?	?	hr. min.

9. Birthplace Troy, N. Y. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frederick C. Kniese
13. Birthplace Denmark

MOTHER
14. Maiden Name Margaret Leahy (Leahy)
15. Birthplace Ireland

16 (a) Informant Dennis L. Bergin
(b) Address 2840 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

JUL 28 1945 (Date received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945 at 5:8A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 27 1945; and that I last saw her alive on July 27, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	6 mos.
Due to Cardiac Hyper-tension and Chronic Nephritis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Norris M. D.
Address 10 W East Ave Md. Signed July 27, 1945.

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Powers Street
(c) Hospital or institution:
13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Powers Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Darry F. Bullson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. M. Married

6 (b) Name of husband or wife Lesta M. Bullson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1877

8. AGE: Years 68 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER
12. Name Enoch Bullson
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma —
15. Birthplace Maryland

16 (a) Informant Mrs. Darry F. Bullson
(b) Address 825 Powers Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28-1945 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Carroll Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 JUL 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25-1945, at 9-15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945, to July 25 1945, and that I last saw him alive on July 23 1945.

Immediate cause of death Cerebral Hemorrhage. — Duration 22 days.

Due to Cardio-renal disease — 5 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 4646 W 36 St. Date signed 7/26/45

VS 150

X

Mabel F. Henry G31109

G31109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard at Green
(c) Hospital or institution: Univ. Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Chestnut Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel F. Henry

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-22-1830

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife William H. Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16, 1882

8. AGE: Years	Months	Days	If less than one day
62	7	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Richard B. Boyer
13. Birthplace Virginia

MOTHER
14. Maiden Name Barbara Reeves
15. Birthplace Virginia

16 (a) Informant William H. Henry
(b) Address 3319 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co., Md.

18 (a) Funeral director Burgyle Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Williams, M.D.

JUL 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24/45 19 , to 7/26 1945 , and that I last saw h~~im~~ alive on 26 1945 .

Immediate cause of death	Duration
Cerebro-vascular accident	
Due to Hypert. Heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard B. Thomas. M. D.
Address Univ. Hospital Date signed 1/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G31110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division Street

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1606 Waldo Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mollie Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-1902

8. AGE: Years	Months	Days	If less than one day
42	10	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Arthur Hill

13. Birthplace Virginia

MOTHER 14. Maiden Name Annie Isaac

15. Birthplace Maryland

16 (a) Informant Owner

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy A. Wilson

(b) Address 200 Brantley Ave

19 (a) Date received JUL 28 1945 (b) Registrar Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945, at 6 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1945, to July 26, 1945, and that I last saw Deceased on July 26, 1945.

Immediate cause of death

Congestive Heart Failure

Duration about 3 weeks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Provident Hospital Date signed 7/27/45

M. D.

G31111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G31111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N. Appleton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Linden Ave. Arbutus
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA STERN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Leon Stern.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 5, 1881

8. AGE: Years	Months	Days	If less than one day
64	6	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Leopold Rose,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rebecca Kraft,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bernice Pitts,
(b) Address 1309 Linden Ave. Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7.29.45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonnenreich & Son
(b) Address 1902 Eutaw Place.

JUL 29 1945 (a) (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 9:25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1942, to July 27 1945, and that I last saw h.CR. alive on July 27 1945

Immediate cause of death: Hypertensive Cardio-Vascular disease — Duration 3 yrs.
Due to Acute Cardiac Dilatation & failure — 12 hours
Due to Diabetes Mellitus — 3 yrs.?
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. Earl Pass, M.D.
Address 4001 Wilkens Ave Date signed 7-28-45

VB 180

G31112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G31112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2336 Pennsylvania Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2336 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME ANDREW YOST

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Elizabeth Yost
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/19/1857

8. AGE: Years 87 | Months 11 | Days 8 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Marienna
15. Birthplace Germany

16 (a) Informant Mr. Carl Yost
(b) Address 2336 Pennsylvania Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

(a) Date received JL 29 1945 (Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to July 27 1945, and that I last saw him alive on July 26 1945.

	Duration
Immediate cause of death: Cardiac Failure	1 wk.
Due to: Arteriosclerotic & Hypertensive C-V. Dis.	2 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Goldstone, M.D.
Address 1423 Linden Av. Date signed July 29, 45

VS 150

G31113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G31113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 S. Curley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence M. La Monaco

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 579-09-3503

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Rose M.

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Jan 11 1904

8. AGE: Years 41 | Months 6 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Mt Savage Md. (Town, county, and state)

10. Usual Occupation Hair Dresser.

11. Industry or business

FATHER 12. Name Salvatore La Monaco

13. Birthplace Italy

MOTHER 14. Maiden Name Michelina Massina

15. Birthplace Italy

16 (a) Informant Rose M. La Monaco

(b) Address 518 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director M. W. E. Oppelt Son

(b) Address Lombard and Sts.

19 (a) JUL 29 1945 (b) Huntington Williams, M.D. (Registrar)

VS 18

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945 at 12:PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1941, to 7/25 1945, and that I last saw h/im alive on 7/25 1945.

Immediate cause of death Myocardial Failure — Duration: 2 mos.

Due to (Cancer) — Duration: 16 Mo. 6 yrs

Other Conditions Carcinoma of Urinary Bladder. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Gillen M. D.

Address 1800 N. Charles St. Date signed 7/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31114

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G31114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4528 Hartford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4528 Hartford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank H. Broadders

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1868

8. AGE: Years 76 | Months 7 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Broadders
13. Birthplace N.C.

MOTHER
14. Maiden Name Margaret Mason
15. Birthplace ?

16 (a) Informant Mrs Mary C. Broadders
(b) Address 4528 Hartford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location

18 (a) Funeral director G. J. Ruck
(b) Address 3305 Hartford Rd

19 (a) Huntington Williamsport
(Date rec'd by registrar) JUL 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to July 27 1945, and that I last saw h/m alive on July 27 1945.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Chronic Myocarditis

Due to Chronic Nephritis

Other Conditions Senility

Due to Uremia - Delirium

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3001 Shannon Drive Date signed July 28-45

VS 150

PLEASE WRITE PLAINLY with pen and ink and avoid the use of symbols or abbreviations. Items are important to the value of the data. Physicians: please write the causes of death clearly and legibly. Use correct age is especially important.

G31115

History No 237532

G31115

Registered No.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Edgewater.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BOSTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Moses Baston
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) November 5, 1900
8. AGE: Years 44 | Months 8 | Days 22 | If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Washington Olney
13. Birthplace unknown

MOTHER
14. Maiden Name Mary Turner
15. Birthplace unknown

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery or crematory Hope Chapel Cem
Location Hope Chapel Md
18 (a) Funeral director Ethel L Hicks
(b) Address [illegible]

JUL 28 1945 (b) Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 11 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945 to July 27 1945, and that I last saw her alive on July 27 1945.

Immediate cause of death: Edema of lungs
Due to: Eclampsia
Due to:
Other Conditions: Pregnancy
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholson T. Eastman M. D.
Address Johns Hopkins Hosp. Date signed 7/28/45

X

G31116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31116 Registered No.

CWK-94685

1 B 2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Washington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Roy Edgar Bennett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Helen Bennett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26-1907

8. AGE: Years	Months	Days	If less than one day
38	4	2	hr. min.

9. Birthplace Williamsport-Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edgar Bennett
13. Birthplace Virginia

MOTHER
14. Maiden Name Irene Trumpower
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery or crematory Rest Haven
Location Hagerstown Md

18 (a) Funeral director H. K. Hoffman
(b) Address Hagerstown Md

19 (a) (Date rec'd by registrar) JUL 29 1945 (b) Huntington-Williamsport

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 28 1945, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945, to July 28 1945, and that I last saw him alive on July 28 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 7-28-45

X

Please write plainly, using pen and ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Entry of information should be carefully supplied.

35 3 5 G31117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139a

G31117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Somerset Co
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-06

8. AGE: Years	Months	Days	If less than one day
39	6	25	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Crab picker

11. Industry or business

FATHER
12. Name Don Henry Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Young
15. Birthplace Maryland

16 (a) Informant Redbrook
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 45 (month) (day) (year)
(c) Cemetery or crematory Marion Cem
Location Marion, Md

18 (a) Funeral director W. Harvey Bradshaw
(b) Address Crisfield, Md

19 (a) 8-6 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945; at 5 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1945 to 7-27-1945 and that I last saw her alive on 7-27-1945

Immediate cause of death Coma, Apnea
due to ? cerebral edema
due to operation for bilateral
Due to tubo-ovarian abscesses,
Due to
Other Conditions Localized peritonitis, pelvic
(Include pregnancy within 3 months of death)

Date of operation 7-26-45

Major findings of operation: Bilateral tubo ovarian abscesses

of autopsy: Above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan, M. D.
Address 8 & N. Broadway Date signed 7-31-45

VS 150

Stationed Camp Pickett, Va

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170 G31118 (over)

G31118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Pa. (b) County BALTO.
(c) City or town BALTIMORE Punxsutawney
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~NONE~~ 125 Clark Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Clark Gretzinger

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W.# 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maxine Gretzinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1919

8. AGE: Years	Months	Days	If less than one day
26	5	5	hr. min.

9. Birthplace Pitcairn, Pennsylvania
(Town, county, and state)
10. Usual Occupation U.S. SOLDIER
11. Industry or business

FATHER — 12. Name	Charles Gretzinger
FATHER — 13. Birthplace	Pa.
MOTHER — 14. Maiden Name	Catherine
MOTHER — 15. Birthplace	West Moreland County, Pa.

16 (a) Informant (over)
(b) Address

17 (a) Burial (b) Date thereof JULY 30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Punxsutawney
Location Pennsylvania

18 (a) Funeral director Lilly & Geiler, Inc.
(b) Address 403 S. WOLFE ST.

19 (a) JUL 29 1945 (b) Huntington, Williamsport, Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 1:40 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest
Extensive third degree burns.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-27-45 at 1:20 P. M.
(b) Where did injury occur? 2700 Clark Wilkens Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Truck & Truck collision

23. Signature Robert Lee Foster M.D.
Medical Examiner.
Date signed July 27 1945

G31119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31119 Registered No.

AB-95032

115c

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs .50min

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1205 Guilyan St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Slayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11-1945

8. AGE: Years	Months	Days	If less than one day
	4 S	16	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stanley Slayton

13. Birthplace W.Va.

MOTHER 14. Maiden Name Gladys Wilson

15. Birthplace W.Va.

16 (a) Informan Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/29/45 (month) (day) (year)

(c) Cemetery or crematory Roncerette

Location W. Va.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St

19 (a) (Date) (b) Huntington Williams, M.D. Registrar

JUL 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27- 19 45 at 6.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27- 19 45, to 7-27 19 45, and that I last saw h im alive on 7-27- 19 45

Immediate cause of death Pharyngitis — Duration

Bacteremia - Toxemia

Due to Organism not identified yet

Due to

Other Conditions Encephalitis?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John E Faulkner M. D.

Address BCH Date signed 7-28-45

X

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

G31120 CERTIFICATE OF DEATH 93E

[redacted] Registered No. G31120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 4630 - Falls Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [redacted] (b) County
(c) City or town (If outside city or town limits, write RURAL. If inside town) [redacted]
(d) Street No. 4650 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kissie Gordon,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race N. of | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Aron Gordon

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1850

8. AGE: Years 93 | Months 4 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Atlanta S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name January Evans

13. Birthplace S. C.

MOTHER 14. Maiden Name Lydia Evans

15. Birthplace S. C.

16 (a) Informant John P. Gordon

(b) Address 1209 - Shields A. P.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1945 (month) (day) (year)

(c) Cemetery or crematory Florence, S C

Location

18 (a) Funeral director Adolphus Holstead

(b) Address 918 - Penrich St Balto

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

JUL 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1945 to 7/24 1945 and that I last saw h[illegible] alive on 7/24 1945

Immediate cause of death Myocarditis — Duration 9

Due to Senility —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson C. Johnson M. D.

Address 1802 Penna Ave Date signed 7/27/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G31121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Crystal Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Bertha Gohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband ~~or wife~~: Otto Gohr

6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Dec 20th 1866

8. AGE: Years 78 | Months 7 | Days 8 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Ulrich Pfeiffer
13. Birthplace Germany

MOTHER
14. Maiden Name Agata (Unknown)
15. Birthplace Germany

16 (a) Informant Herman C. Hunderthark
(b) Address Linthicum Hghts P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) 7-31-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1945, to 7/28 1945, and that I last saw her alive on 7/28 1945

Immediate cause of death	Duration
Aortic thrombosis	
Due to Hypertensive cardio	
Due to vascular disease	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Traynor M. D.
Address Md. Gen. Hosp. Date signed 7/28/45

X

G31122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓G31122

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1668 W. North Ave

(c) Hospital or institution:

15th

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1668 W. North Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Ella D. Hibbard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Wid

6 (b) Name of husband or wife James Hay

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16-1862

8. AGE: Years 83 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Berryville Va.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George S. Johnston

13. Birthplace Va.

MOTHER

14. Maiden Name Mary Rice

15. Birthplace Va.

16 (a) Informant Helen M. Hibbard

(b) Address 1668 W. North Ave

17 (a) Burial (b) Date thereof 7/30/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Hill Cem.

Location Berryville Va.

18 (a) Funeral director Wm Cook Inc

(b) Address 1617 St Paul St

19 (a) (Date received by registrar) (b) Huntington Williams M.R. Registrar

JUL 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/45 19 , at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 19 45 to July 27 19 45 and that I last saw h alive on July 27 19 45

Immediate cause of death

Angina Pectoris

Due to Senile Degeneration

Due to

Other Conditions Diabetes not known

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

Duration

not known

several years

not known

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Roscoe G. Inloes M. D.

Address 247 S. Howard St. Date signed July 28 1945

(18) 94B

Please write plainly with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G31123 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2427 Barclay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 N. Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Ross Nicholson

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Winfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1865

8. AGE: Years 80 | Months 1 6 | Days 24 | If less than one day hr. min.

9. Birthplace Buoyrus, Ohio
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name John Ross
13. Birthplace Ohio

MOTHER
14. Maiden Name Lucinda Thorpe
15. Birthplace Ohio

16 (a) Informant Miss Margaret Nicholson
(b) Address 2427 Barclay Street

17 (a) Burial (b) Date thereof 7-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory David Gilpin
Location Dikesville, Md.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUL 30 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1944 to July 27 1945
and that I last saw h alive on July 26 1945

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Uremia Sclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Ehrman M. D.
Address 4436 5th Date signed 7-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

X

G31124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31124

Registered No. 30c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1717 Lamont Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 29

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1717 Lamont Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Paul L. Kirk

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	213-07-3896

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1889

8. AGE: Years	Months	Days	If less than one day
56	1	15	hr. min.

9. Birthplace Sylmar, Md (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER

12. Name Alfred A. Kirk

13. Birthplace Md

MOTHER

14. Maiden Name Emma Hynes

15. Birthplace Md

16 (a) Informant Mrs Virginia Kirk

(b) Address 1717 Lamont Ave

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7/28/45 (month) (day) (year)

(c) Cemetery or crematory New London

Location New London Md

18 (a) Funeral director Milton Kirk Inc

(b) Address 1217 Park Ave

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 4:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1945 to 7/26 1945, and that I last saw h[illegible] alive on 7/25 1945.

Immediate cause of death Central Nervous System Syphilis

Due to (Paresis)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 3 years?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. L. Smith

Address 1223 E Monk Ave Date signed 7/29/45

VS 150

X

G31125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31125

G31125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Liberty Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Bernard Brydon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Henrietta Seymour Brydon
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 27, 1879

8. AGE: Years	Months	Days	If less than one day
65	11	-	hr. min.

9. Birthplace Bloomington, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name William A. Brydon
13. Birthplace Rome, N. Y.

MOTHER
14. Maiden Name Susan V. Brady
15. Birthplace Frankfort, W. Va.

16 (a) Informant Mrs. Henrietta S. Brydon
(b) Address 4509 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Wilkes Lamotte
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar) JUL 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 11.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to July 1945 and that I last saw alive on 7-27 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hrs

Due to: Hypertensive Cardio Vas. — 4 yrs

Due to: Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. P. Scott M. D.
Address 4509 Liberty Hts Ave Date signed

I correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G31126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5305 Bosworth Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5305 Bosworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ellen Langstaff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Langstaff
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) November 30, 1861

8. AGE: Years	Months	Days	If less than one day
83	7	27	hr. min.

9. Birthplace Hartford City, Ind.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Hoffman
13. Birthplace Indiana

MOTHER
14. Maiden Name Unknown
15. Birthplace Indiana

16 (a) Informant Mrs. W. J. Urban
(b) Address 5305 Bosworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lamonaca
(b) Address 4520 Liberty Heights Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.
JUL 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to July 27 1945, and that I last saw h[illegible] alive on 7/26 1945.

Immediate cause of death: Cerebral edema — Duration: 1 mo[illegible]
Due to: Arteriosclerosis
Due to: Age
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Klemmt M. D.
Address 4710 Liberty Hgts Ave. Date signed

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G31127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2022 E. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: SOPHIE –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 47 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor (Self)

11. Industry or business

FATHER
12. Name Russia –
13. Birthplace Russia

MOTHER
14. Maiden Name Slatta –
15. Birthplace Russia

16 (a) Informant Mrs. Sophie Cohen
(b) Address 2022 E. Fairmount Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-29-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Jack Spiro Inc

18 (a) Funeral director 1939 E. Balto. St.
(b) Address

29 1945 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 4:46 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gratton M.D.
Medical Examiner.
Date signed July 28, 1945.

VS 151

G31128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59. | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Tailor (Self)

11. Industry or business

FATHER
12. Name Hyman Jos. Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Peza-
15. Birthplace Russia

16 (a) Informant Jacob Cohen (Bro)
(b) Address 1507 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jacob Heine Inc
(b) Address 1439 E. Balto. St

19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 19 45 at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection on Autopsy, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Lubarsky M.D.
Medical Examiner.
Date signed 5/6/46

VS 151

G31129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31129

Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 E. 2nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John S Etzler

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Lucy Etzler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7, 1893

8. AGE: Years	Months	Days	If less than one day
51	7	14	hr. min.

9. Birthplace Frederick Co Md.
(Town, county, and state)
10. Usual Occupation Retired Foreman
11. Industry or business Brush Business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Ruth Sheets
15. Birthplace Frederick Md

16 (a) Informant Lucy Etzler
(b) Address Frederick Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Frederick, Maryland

18 (a) Funeral director M. R. Fleshman & Son
(b) Address Frederick, Maryland

19 (a) 29 1945 (b) Signature or registrar Hilbert Nottingham Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945 at 6:45 P M

21. I certify that I took charge of the remains described above, held an Inspection - Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following. Code 138
(a) Date of injury 7/28/45 at about 11:30 A.M.
(b) Where did injury occur? White Hall Md.
(c) Did injury occur at home, on farm, industrial place, in public place? County Highway While at work? Yes
(d) Means of injury Struck by falling object while driving truck

23. Signature C. F. Culbreath M.D.
Medical Examiner.
Date signed 7/28/45

G31130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G31130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 S Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 S Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gmelig Ros (Ross)

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph Ros

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name Karyto
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Burton Ros
(b) Address 417 S Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) JUL 29 1945 (Date received by registrar) (b) Huntington Hilltop Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 405 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 45 to July 26 19 45
and that I last saw him alive on July 26 45

Immediate cause of death Carcinoma of Stomach — Duration about 1 year

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 416 Cathedral St Date signed 7-28-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G31131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G31131 Registered No.

PLEASE PRINT PLAINLY, with INK and DO NOT FOLD. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Juliana Zygowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Mathew Zygowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Daughter Frances
(b) Address 516 S Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30/45 (month) (day) (year)
(c) Cemetery or crematory Leonard Hebert Cemetery
Location Baltimore

18 (a) Funeral director Fred W Ozgazynski
(b) Address 1930 Eastland Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 28 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945 at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1945 to July 26 1945 and that I last saw h[im] alive on July 26 45.

Immediate cause of death ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration: APRIL 1945

Due to

Due to

Other Conditions LOBAR PNEUMONIA — Duration: 4/16-30/45

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jeff E Arenga M.D.
Address 2091 Chester St Date signed 7/28/45

93D

G31132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G31132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Somers Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Somers Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie L. Higgins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife Charles R. Higgins
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov - 8 - 1886

8. AGE: Years	Months	Days	If less than one day
58	8	20	hr. min.

9. Birthplace Ash Co. N. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Noah [illegible] Long
13. Birthplace Wilkesboro

MOTHER
14. Maiden Name Lora Ryles
15. Birthplace Wilkesboro

16 (a) Informant James H. Higgins
(b) Address North Wilkesboro N.C.

17 (a) Burial (b) Date thereof 7 - 31 - 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location North Wilkesboro N.C.

18 (a) Funeral director T. H. Colley Inc
(b) Address 2435 E. Oliver St.

29 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to July 28 1945, and that I last saw her alive on July 28 1945.

Immediate cause of death Carcinoma of Breast — Duration 18 mos

Due to Metastasis to Lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Coral Gordon M. D.
Address 2201 W. North Ave. Date signed 7-28-45

X

G31133
AB-94991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (1147)

G31133

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2542 Frances St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles McCubbins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6- 1897 ?

8. AGE: Years	Months	Days	If less than one day
47?	11	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Baltimore City

FATHER
12. Name James McCubbins
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma ?
15. Birthplace Baltimore, Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/45
(month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East of E. North ave

18 (a) Funeral director John J. Howard & Son
(b) Address 2203 Wallis St.

19 (a) JUL 29 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27- 1945, at 8.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25- 1945, to 7-27- 1945, and that I last saw him alive on 7-27-45 19

Immediate cause of death	Duration
Lung abscess	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 7-28-45

G31134

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G31134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 Mt. Henry Av.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Mt. Henry. (If rural give location)
(e) Citizen of foreign country? ... (Yes or No) If yes, name country ...

3 (a) FULL NAME Carrie W. Lucas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife late Charles W.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	15	hr. ... min.

9. Birthplace Philadelphia Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name John J. Neal
13. Birthplace Jersey City

MOTHER
14. Maiden Name Carrie Hatfield
15. Birthplace Philadelphia Pa.

16 (a) Informant Mrs. Edwin A. Howard
(b) Address 1825 Mt. Henry St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director John J. Howard & Son
(b) Address 2403 Pollitt St

19 (a) JUL 29 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1945 to 7/27 1945 and that I last saw her alive on 7/27 1945

Immediate cause of death: Arteriosclerotic cardio vascular disease — Duration 2 mos

Due to: — Duration —

Due to: — Duration —

Other Conditions Cerebral hemorrhage — Duration 10 days

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ...
(e) Means of injury ...

23. Signature Benjamin Miller M. D.
Address 2010 W. Lafayette Ave Date signed 8/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green St., Balto. Md
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll Co
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 47 W. Green St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL G. LEWIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dr. E. R. Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1888

8. AGE: Years 56 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Home-wife

11. Industry or business

FATHER 12. Name Richard Ball

13. Birthplace Va.

MOTHER 14. Maiden Name Emma Sutherland

15. Birthplace Va.

16 (a) Informant Dr. E. R. Lewis

(b) Address 47 W. Main St Westminster Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 7 29 45

(c) Cemetery or crematory Westminster Cem

Location Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.

(b) Address Westminster, Md.

19 JUL 30 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29/45, at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/45 19__, to 7/29 19 45 and that I last saw h__ alive on 7/29 19 45

Immediate cause of death Pulmonary Embolism

Due to Pulmonary Embolism

Due to

Other Conditions Pulmonary Tbc.

(Include pregnancy within 3 months of death)

Date of operation July 17 1945

Major findings of operation: Tbc. Lung

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas G. Lewis M. D.

Address Univ. Hosp. Date signed 7/29

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E Registered No. 631136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Woodland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bruce M Griffin Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1933

8. AGE: Years	Months	Days	If less than one day
11	11	16	hr. min.

9. Birthplace Paradise Valley, Calif.
(town, county, and state)

10. Usual Occupation ~~School~~ Student

11. Industry or business School.

FATHER
12. Name Lt. Bruce M. Griffin
13. Birthplace Pittsboro, N.C.

MOTHER
14. Maiden Name Effie Frances Cole
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bruce M. Griffin
(b) Address 3020 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Young Bros
(b) Address 5005 Pk Heights Ave.

19 (a) JUL 30 1945 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945, at 6 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 21 1945 - 2117 5 P.M.
(b) Where did injury occur? 3020 Woodland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged by strap

23. Signature Robert Lee Taylor M.D.
Medical Examiner.
Date signed July 22 1945.

VS 151

G31137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G31137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 S. Furrow St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Furrow St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Will

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	10	28		

9. Birthplace: Poland (Town, county and state)

10. Usual Occupation: Cabinet Maker

11. Industry or business: Retired

FATHER
12. Name: Unknown
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Martha Will
(b) Address: 220 S. Furrow St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Anne Arundel County, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave.

JUL 30 1945

(a) (Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2/1941 to 7/26/1945 and that I last saw him alive on 7/25/1945

Immediate cause of death: Hypertensive Cardio vascular disease — Duration: 4 yrs

Due to: —

Due to: —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel, M. D.
Address 1226 Hanover St. Date signed 7/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. G31138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Harrisonburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 S. Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alvin Dey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-02

8. AGE: Years 43 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER 12. Name Henry Dey
13. Birthplace Va

MOTHER 14. Maiden Name Julia Salomon
15. Birthplace Md

16 (a) Informant Kuranda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1-1945 (month) (day) (year)
(c) Cemetery or crematory Jewish Cem.
Location Harrisonburg Va

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Main St

19 (a) JUL 30 1945 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 10 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 29 1945, and that I last saw him alive on July 29 1945

Immediate cause of death	Duration
CARDIAC FAILURE	4 wks
Due to CHRONIC GLOMERULO-NEPHRITIS	1 15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson M.D.
Address Johns Hopkins Hospital Date signed 7/29/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 631139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Sabillasville (If outside city or town limits, write RURAL and give town)
(d) Street No. State Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maude Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-08

8. AGE: Years 36 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Cafeteria work

11. Industry or business

FATHER
12. Name Thomas Collins
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret Edwards
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Beach Haven
Location Berwick Pa

18 (a) Funeral director H. H. Wilkie
(b) Address 410 Edmondson ave

19 JUL 30 1945 (b) Huntington Williams Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to July 29 1945 and that I last saw her alive on July 29 1945

Immediate cause of death Paraplegia cerebrum traffy cardiac, TB Pulmonary

Due to Post operation Pneumoplasty, 2nd Stage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-29-1945

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Mengert Jr. M.D.
Address The Johns Hopkins Hosp Date signed 7-29-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87C

Registered No. G31140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Kenture Key Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Kenture Key Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John F Matthews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1864

8. AGE: Years	Months	Days	If less than one day
81	1	29	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation
11. Industry or business Home

FATHER
12. Name John Goldstein
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Buchmeier
15. Birthplace Balto

16 (a) Informant Mrs Jacob Sauer
(b) Address 2400 Kenture Key Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1945 (month, day, year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Wm. J. Linnard Home
(b) Address 2008 Orleans St

19 (a) (Signature of registrar) (b) Huntington Williamson, M.D.

JL 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1945 at 3-a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to 7/27 1945
and that I last saw alive on 7/25 1945

Immediate cause of death	Duration
Pulmonary Disease	10 years
Due to Arteriosclerosis (Cerebral)	15 years
Due to Arteriosclerosis (Generalized)	15 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Thompson M. D.
Address 214 Medical Arts Bldg Date signed 7/27/45

VS 180

PLEASE WRITE PLAINLY, with pen and ink. Use no abbreviations. Be accurate and complete. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G31141 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1005 Spangler Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Elliott Stanger. Stanger.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21 1927

8. AGE: Years 17 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Allentown Pa (Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business

FATHER 12. Name Jacob Stanger

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Diener

15. Birthplace Allentown Pa

16 (a) Informant Jacob Stanger

(b) Address 1005 Spangler Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 31-45 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial Park

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2002 Aliceanna St

19 (a) JUL 30 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy/Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive 2nd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 12/5

(a) Date of injury 7-25-45 3 P.M.

(b) Where did injury occur? Yellow Cab Co. - Balto. 30 E. Pratt St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes

(d) Means of injury Gasoline exploded.

23. Signature Richard Lee Grafton M.D. Medical Examiner.

Date signed July 27 1945

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G31142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G31142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Eutaw, Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erma Sue Kibbey

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/45

8. AGE: Years | Months 4½ mo. | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John A. Kibbey
13. Birthplace Kentucky

MOTHER
14. Maiden Name Venus Williams
15. Birthplace Kentucky

16 (a) Informant Mr. John A. Kibby
(b) Address 2019 Eutaw, Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Fredrick Rd.

18 (a) Funeral director John A. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) JUL 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945 to July 28 1945 and that I last saw her alive on July 28 1945.

Immediate cause of death Pneumonia with atelectasis — Duration

Due to

Due to

Other Conditions Possible Acute leukemia — Duration: over

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: Pneumonia with atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnall Pak M. D.
Address Sinai Hosp Baltimore, Md. Date signed 7-28-45

109

VS 150

Physicians: please write the causes of death clearly and legibly. Be sure to state, with sufficient detail, the exact cause of death, so that the correct age is especially important.

631143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓ Registered No. 631143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Harwell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jennison

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 216-03-5168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ruth Sturm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19th, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Ford & Co.

FATHER
12. Name Wm. N. Jennison
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Lewis
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Ruth Jennison
(b) Address 3206 Harwell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director E. D. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 JUL 30 1945 (Date rec'd by registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945 at 2 30 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Raul Le Fevre M.D. Medical Examiner.
Date signed July 27 1945

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G31144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓ Registered No. G31144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Reservoir St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Helen A. Bartlett CONFIRMING

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 21 1866
8. AGE: Years 78 | Months 9 | Days 6 | If less than one day: hr. min.
9. Birthplace Philadelphia Pa (Town, county, and state)
10. Usual Occupation (Retired) Nurse
11. Industry or business

FATHER
12. Name J. Kemp Bartlett
13. Birthplace Maryland

MOTHER
14. Maiden Name Virginia Cowgill
15. Birthplace Delaware

16 (a) Informant
(b) Address Mr. H. Bartlett Jr. - Woodbrook Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Friends
Location Harford Ave., City

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 JUL 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1945 at 7 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1945 to 7-27 1945 and that I last saw h.e alive on 7-27 1945

Immediate cause of death Paralysis Ileus — Duration

Due to ?

Due to

Other Conditions Parkinsonism Arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Shipley M.D.
Address Church Home & H. Date signed 7-27

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G31145

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution: Union Memorial Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2632 Maryland Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Blanche Irene Walmsley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Wm. N. Walmsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About December 7, 1885

8. AGE: Years	Months	Days	If less than one day
Abt 60 59	0 7	5 26	hr. min.

9. Birthplace Baltimore, Maryland (Frederick Co.)

(Town, county, and state)

10. Usual Occupation Nana

11. Industry or business

FATHER

12. Name Jerome Pampell

13. Birthplace Va.

MOTHER

14. Maiden Name Arianna Morgan

15. Birthplace Maryland

16 (a) Informant William Walmsley (son)

(b) Address 2632 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Woodlawn

Location

18 (a) Funeral director Sherwood Memorial

(b) Address 1015 W. Fayette St.

19 (a) JULY 30 1945 (b) Huntington Wilson, M.D.

(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17, 1945 to July 28, 1945, and that I last saw her alive on July 28, 1945

Immediate cause of death	Duration
Coronary Occlusion ?	
Due to Arteriosclerotic hypertensive Cardiovascular Disease	
Due to	
Other Conditions Bronchial Asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Frank Supplee III

Address Union Memorial Hospital Date signed 7/28/45 (M. D.)

VS 150

Please write plainly, preferably with typewriter. Use no abbreviations. Do not use ditto marks. Be sure that the information supplied is complete and correct. Do not omit any items. If unknown, state so. Physicians: please write the causes of death clearly and legibly. Cause of death is especially important.

G31146

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31146

Registered No.

CERTIFICATE OF DEATH 46 E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd street
(c) Hospital or institution:
Union memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County Dade Co.
(c) City or town Miami (Coconut Grove)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 main Highway Coconut Grove
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Richards A. Meeker (Helen Painter) (Helen Painter Meeker)

3 (b) If veteran, name war 0

3 (c) Social Security Account No. 0

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband ~~or wife~~ Richards A. Meeker

6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 6/2/1867

8. AGE: Years 78 | Months 1 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Balti-Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business 0

FATHER
12. Name William Painter
13. Birthplace Pennsylvania Fallston Md

MOTHER
14. Maiden Name Harriet Deacon
15. Birthplace Phila-Pennsylvania

16 (a) Informant self. Wm. P. Meeker (son)
(b) Address 44 Harrington Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville-Md

18 (a) Funeral director Sherwood Memorial
(b) Address 108 W Mount Royal

19 (a) JUL 30 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1945, to July 28 1945.
and that I last saw h.e.r. alive on July 27 1945.

Immediate cause of death Cardiac failure — Duration: over

Due to Intestinal obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/17/45

Major findings of operation: annular growth in descending colon.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Streeter O.K. M. D.
Address Date signed

VS 150

X

PLEASE WRITE LEGIBLY. Use only black ink. Entries must be complete and accurate. Do not abbreviate or use ditto marks. Avoid use of illegible or ambiguous terms. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G31147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 Moreland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Moreland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Rosenberg

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Maurice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Boruch
13. Birthplace Russia

MOTHER
14. Maiden Name Fayner
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Philadelphia Rd & Rawlings Lane
18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Baltimore St
19 JUL 30 1945 (b) Huntingtown Williamsport Md
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11 1945 to 7/28 1945 and that I last saw he alive on 7/26 1945

Immediate cause of death	Duration
Carcinoma of stomach	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov 1, 1944
Major findings of operation: Carcinoma of stomach with metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 203 Wilkens Ave Date signed 7/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

1148 G31148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 715
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Waldo Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jenkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/45

8. AGE: Years	Months	Days	If less than one day
			8 hr. 30 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name David Myous
13. Birthplace Unknown

MOTHER
14. Maiden Name Princel Jenkins
15. Birthplace Maryland

16 (a) Informant J.H.H. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 30 1945 Date rec'd by registrar Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 9:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to July 17 1945, and that I last saw her alive on July 17 1945.

Immediate cause of death	Duration
Ateleotasis	
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

2574 X

31149 Twin B H-26457 ✓ G31149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address The Johns Hopkins Hospital
(c) Hospital or institution:
The Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/45

8. AGE: Years	Months	Days	If less than one day
		29 days	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Herman Mitchell
13. Birthplace Virginia

MOTHER
14. Maiden Name Arvilla Johnston
15. Birthplace Alabama

16 (a) Informant J.H.H. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director
(b) Address Commissioner of Health

19 JUL 30 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1945 to July 17 1945, and that I last saw h er alive on July 17 1945.

Immediate cause of death	Duration
diarrhea	
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.

Address Date signed

875 X

G31150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓ G31150 Registered No.

JO #15625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore city Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19yrs. 6mos. 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Broadwater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	-5-	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Richard Morris
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address
19 JUL 30 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 18, 1926 to July 22, 1945, and that I last saw her alive on July 22, 1945.

Immediate cause of death Respiratory failure — Duration

Due to Cardiac failure

Due to arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address A.C.H. Date signed 7/27/45

VS 150

2876

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

31151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15,1945

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name George Norris
13. Birthplace Maryland

MOTHER
14. Maiden Name Lavallia Powell
15. Birthplace North Carolina

16 (a) Informant J.H.H. Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 30 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1945, at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945, to July 20 1945, and that I last saw her alive on July 20 1945.

Immediate cause of death ? Aspiration pneumonia — Duration

Due to

Due to

Other Conditions Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

577

107

31152

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

119a

Registered No. G31152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a. a. Co.
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Boy Cauley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-45

8. AGE: Years	Months	Days	If less than one day
	1	6 Wks.	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name J. Cauley
13. Birthplace Va

MOTHER 14. Maiden Name Ruby ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL JUL 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address
(c) JUL 30 1945 (Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1- 1945 to 7-18 1945.
and that I last saw h im alive on 7-18 1945.

Immediate cause of death Prematurity — Duration: 2 Wks
Due to Diarrhea
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence D. Hall M. D.
Address Hopkins Hosp Date signed 7-18-45

VS 150

T-878

G31153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1157

Registered No. G31153

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1822 E Biddle St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linwood Paylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Colored	Seperated

6 (b) Name of husband or wife Gertrude C. Paylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30, 1913

8. AGE: Years	Months	Days	If less than one day
32 31	7	28	hr. min.

9. Birthplace North Carolina (Town, county and state)

10. Usual Occupation Laborer - Bethlehem Steel

11. Industry or business

FATHER 12. Name Heatham Paylor

13. Birthplace Roxboro N. Carolina

MOTHER 14. Maiden Name Ruth Rodgers

15. Birthplace Roxboro N. Carolina

16 (a) Informant Willie Paylor

(b) Address 1227 Harford Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 31 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Roxboro N. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott

(b) Address 129 N. Carolina St.

19 (a) AUG 3 0 1945 (Registrar's date)

Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945, at 7:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 1945 to 7/28 1945 and that I last saw him alive on 7/28 1945

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Septicemia staph aureus	
Due to Ludwigs Angina	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene J Riley M.D.

Address Date signed 7/28/45

VS 150

G31154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

G31154

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St.

(c) Hospital or institution: Little Sisters of the Poor

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1200 Valley St

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margarete Wise

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1859

8. AGE: Years 86. Months May Days 27 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Joseph Taylor

13. Birthplace U.S.A.

MOTHER 14. Maiden Name Elizabeth ?

15. Birthplace U.S.A.

16 (a) Informant Little Sisters of the Poor

(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location B.A. Co.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

AUG 3-0 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945 to July 28 1945, and that I last saw her alive on July 28 1945

Immediate cause of death Myocardeta + Hypertention

Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence — at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?

(e) Means of injury

23. Signature Elliott Duke M.D. M. D.

Address 9289 E. North Av Date signed 7/29/45

G31155

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31155 Registered No.

CERTIFICATE OF DEATH 12

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address S.
(c) Hospital or institution: S. Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A Co.
(c) City or town Elvaton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence M Wade ✓

3 (b) If veteran, name war No

3 (c) Social Security Account No. 215-09-6818

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Myrtle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1907

8. AGE: Years	Months	Days	If less than one day
38	2	11	hr. min.

9. Birthplace Severn Md.
(Town, county, and state)

10. Usual Occupation Yeast Worker

11. Industry or business Federal Yeast Corp.

FATHER
12. Name Wm Wade
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Wheeler
15. Birthplace Md

16 (a) Informant Myrtle Wade
(b) Address Elvaton Md

17 (a) Burial (b) Date thereof 8-1-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville

18 (a) Funeral director Wm Cook Jr
(b) Address 1212 St Paul St

19 (a) (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

JUL 30 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1946 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1946 to 7-27 1946 and that I last saw him alive on 7-27 19 46

Immediate cause of death	Duration
Acute Tetanus	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R L Sappington M. D.
Address 7-27 46 Date signed

X

G31156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G31156 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Bretton Md. P.O.
(b) Street address 407 Bonston Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, print RURAL and give town)
(d) Street No. 407 Benston Place
(If rural give location)
(e) Citizen of foreign country? Bretton (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Finnerty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age 1866

7. Birth date of deceased (mo., day, yr.) Nov. 27 1875

AGE: Years	Months	Days	If less than one day
64	8	2	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Bernard J Finnerty

13. Birthplace Ireland

MOTHER 14. Maiden Name Anna Langan

15. Birthplace Balto

16 (a) Informant Adele Beneste

(b) Address 407 Bretton Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral ~~Cedar Hill Cem~~

Location ~~A A Co.~~ Balto. Md.

18 (a) Funeral director Wm Cook Inc

(b) Address 1217 St Paul St.

19 (a) ~~July 30 1945~~ (Date rec'd by Registrar) Thurlington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1940 at 5:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature G. F. Sulzbacher M.D.
Medical Examiner.

Date signed 7/29/40

(over)

G31157

475 & 81

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 160a

G31157 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 W. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walker. Kenneth Walker #1

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-45

8. AGE: Years	Months	Days	If less than one day
	1.	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Walker
13. Birthplace Md

MOTHER
14. Maiden Name Gwendolyn Bogle
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (Registered by registrar) JUL 30 1945

Huntington Mill Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 12.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945, to July 25 1945, and that I last saw him alive on July 25 1945:

Immediate cause of death ? Cerebral accident
Pneumonia
Due to Aspiration? Cerebral accident?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond
Address Date signed M. D. 7/28/45

X

G31158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G31158 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 445 Druid St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 445 Druid St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Lena E. Roberts

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Richard M. Roberts
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 28, 1894
8. AGE: Years 53 Months 7 Days 29 If less than one day ... hr. ... min.
9. Birthplace Balto, Md. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Staubitz
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Richard M. Roberts
(b) Address 445 Druid St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) Filed JUL 30 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945 to 7/26 1945; that I last saw h[illegible] alive on 7/26 1945.

Immediate cause of death Hemiplegia — apoplexy — Duration 1 hour
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight D. Fiddes
Address 3323 E. Baltimore Date signed 7/27/45 M. D.

VS 180

G31159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 N. Bruce St
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Bell Hawkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	married

6 (b) Name of husband or wife Leo Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1907

8. AGE: Years	Months	Days	If less than one day
38	1	21	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Philip Freeman
13. Birthplace Va

MOTHER
14. Maiden Name Lena Roane
15. Birthplace Va

16 (a) Informant Leo Hawkins
(b) Address 1424 N Bruce St

17 (a) Burial (b) Date thereof 7-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1307 Baltimore Ave Huntingtown, Md

19 (a) JUL 30 1945 Huntingtown Md
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 2 35 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945 to July 26 1945, and that I last saw her alive on July 26 1945.

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature H Cecil Conner M. D.
Address 1131 Harlem Date signed

Please read carefully, and if any of the questions do not apply, write "None" so that no space may be left for additional entries. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied, correct age is especially important.

med E631160 case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G31160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Lisle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-11-45

8. AGE: Years | Months | Days: 17 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER 12. Name: James Lisle
13. Birthplace: Md.

MOTHER 14. Maiden Name: Anna Scheiner
15. Birthplace: Md.

16 (a) Informant: Mary Allen Enzie
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: Frank Enoch & Son
(b) Address: 900 W. Chester St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mortuary

JUL 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28-1945 to 7-28-1945 and that I last saw her alive on 7-28-1945

Immediate cause of death: Unknown* — Duration: 3 Day
Died 6 minutes after arrival.
Due to
Due to
Other Conditions: Enlarged liver
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Pneumonia with bilat. pleural effusion
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Blair Everett Batson Assistant Resident M. D.
Address Date signed

Approved by Lu Graham M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31161 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Glenmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH SIMONINI.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Charles Lo. Simonini
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1859

8. AGE: Years	Months	Days	If less than one day
85	7	21	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)
10. Usual Occupation House-wife.
11. Industry or business At home.

FATHER
12. Name Michael Boller
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Wideland
15. Birthplace Germany

16 (a) Informant Rinaldo Lo. Simonini (Son)
(b) Address 3018 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. Rd. Balto. Co.

18 (a) Funeral director L. Hemmann & Son.
(b) Address 32 So. Broadway

19 (a) (Date received by Registrar) JUL 30 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945, to July 27 1945, and that I last saw her alive on July 20 1946.

	Duration
Immediate cause of death Cardiac failure	
Due to Arteriosclerotic C-V disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd. Date signed 7-27-45

X

G31162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G31162 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2131 Division St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Austin W. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Rosa L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	22	hr. min.

9. Birthplace Elkridge, Md. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm A. Williams
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Rawlings
15. Birthplace Maryland

16 (a) Informant Rosa L. Williams
(b) Address 2131 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Elkridge, Md.

18 (a) Funeral director Mrs. George A. Hoffman
(b) Address 1631 Edmondson Ave.

19 (a) (Date rec'd [illegible] 30 1945 Undertaking for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1945, at 8 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 44 to 7/27 1945 and that I last saw him alive on 7/27/45.

Immediate cause of death Chr. Nephritis-Uremia

Due to Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. A. Rhett M. D.
135 Dover St Date signed 7/29/45

G31163

HEP #94974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓136B

G31163 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4-V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Hrs & 40 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 657 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1912

8. AGE: Years	Months	Days	If less than one day
32	28 10	0	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Truck Helper
11. Industry or business S. & L. Distributors-Beer

FATHER
12. Name Robert Kelly (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty ? (D)
15. Birthplace New York

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof July 1945
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director A Hahn
(b) Address 918 Lexington Building

19 (a) (Date received by local registrar) (b) Huntington, Maryland
JUL 30 1945
Not to be approved by the Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1945, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25, 1945, to July 25, 1945, and that I last saw him alive on July 25, 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Postoperatively	2 hrs.
Due to	
Other Conditions Periurethral abscess	

(Include pregnancy within 3 months of death)

Date of operation 7-25-45

Major findings of operation: Periurethral abscess

of autopsy: Bilateral pleural effusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto. City Hospitals Date signed 7-27-45

Witnessed X Robert Lee Fretwell M. D.

G31164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 117a

Registered No. G31164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 Berry Street
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Years

13-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Berry Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Felix Henry Decker

3 (b) If veteran, name war --

3 (c) Social Security Account No. 217-01-3074

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie E. Decker

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 12, 1872

8. AGE: Years 73 | Months -- | Days 16 | If less than one day: ____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace --

MOTHER
14. Maiden Name Unknown
15. Birthplace --

16 (a) Informant Fannie E. Decker
(b) Address 620 Berry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date received by Local Registrar JUL 30 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to July 28 1945. and that I last saw h[im] alive on July 14 45

Immediate cause of death: Gastric Ulcer — Duration: 3 years

Due to: Internal Hemmorhage — Duration: 1 hour

Due to: from his ulcer

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Weinstock M. D.

Address 4603 Park Heights Ave Date signed 7/29/45

X

I hereby certify that I attended the deceased from the date and to the date above stated, and that I last saw h[im] alive on the date above stated, and that death occurred on the date above stated, at the hour stated, from the cause and on the date above stated. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Please answer all questions, where applicable, and correct age is especially important.

G31165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G31165

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) one hour

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 West Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CATHERINE Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-3-1892

8. AGE: Years 52 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Cora Fisher
(b) Address 23 W. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto, Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penn Ave

19 (a) (Date rec'd by registrar) JUL 30 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29/45 19 , at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained at Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 7/30/45

G31166 HEALTH DEPARTMENT—CITY OF BALTIMORE G31166

CERTIFICATE OF DEATH 1938

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. East Ave St., 11 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 69 yrs. 2 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Joseph Metzger

If U. S. Veteran specify WAR

(a) Residence: No. 711 S. East Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frances C. Metzger

6. DATE OF BIRTH (month, day, year) Dec 25 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Janitor (Retired)

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Copper Melt

10. Date deceased last worked at this occupation (month and year) Many yrs ago

11. Total time (years) spent in this occupation 20 yrs

12. BIRTHPLACE (city or town) (State or country) Unknown Germany

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown Germany

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown Germany

17. INFORMANT Freda M. Metzger

(Address) 711 S. East Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Sacred Heart Cem Date 7/31/45 19

19. UNDERTAKER Luther Ziegler Co

(Address) 403 N. Wolfe St.

20. FILED JUL 30 1945 19 Huntington Williams M.D.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 28, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 16 1935 to July 28 1945

I last saw him alive on July 27, 1945. Death is said to have occurred on the date stated above, at 12:05 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic C.V. Disease	1-16-36
Chronic Myocarditis	6-11-40
Acute Coronary Occlusion	7-25-45

Other contributory causes of importance:

None.

Was an operation performed? None Date of

For what disease or injury? None

Name of operation None

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) E. H. Schimunek M. D.

(Address) 842 S. East Ave 7-28-45

X

1167.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1167

Registered No. G31167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2927 Edison Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Cymek

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theodore

6 (c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): 2/26/21

8. AGE: Years: 24 | Months: 5 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Warren, Pa. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael Bielecki
13. Birthplace: Poland

MOTHER
14. Maiden Name: Helen Pelc
15. Birthplace: Poland

16 (a) Informant: Mrs. Alice Bielecka
(b) Address: 621 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/45 (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18 (a) Funeral director: M. J. Sobonski & Sons
(b) Address: 1805 Eastern Ave

19 JUL 30 1945 (Date accepted by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Multiple Stab Wounds

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-27-45 at M.
(b) Where did injury occur? 2927 EDISON HIGHWAY
(c) Did injury occur at home, on farm, industrial place, in public place? HOME While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Gray M.D. Medical Examiner
Date signed July 28 1945

VS 151

X

G31168 STATE OF MARYLAND—CERTIFICATE OF DEATH G31168

1. PLACE OF DEATH — 183a

County ..... Registration Dist. No. .....

Village or City Baltimore City ..... No. ..... St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. 14 mos. 2 ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME Mary E. Duvall — If U. S. Veteran, specify WAR .....

(a) Residence: No. 1708 Fortaw Place St., Ward: (illegible)

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Duvall

6. DATE OF BIRTH (month, day, and year) Nov 8-1862

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	8		

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. .....

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. House wife

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Anne Arundle Co (State or country) Mayland

FATHER

13. NAME Franklin Frisbee

14. BIRTHPLACE (city or town) (State or country) Mayland

MOTHER

15. MAIDEN NAME Elizabeth Harlup

16. BIRTHPLACE (city or town) (State or country) Mayland

17. INFORMANT Ellen Brady (Address) Laurel Md

18. BURIAL, CREMATION, OR REMOVAL Place Savage Md Date Aug 1 19 45

19. UNDERTAKER Ridgely Selby (Address) 40 Wood st Laurel Md

20. AUG 30 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 29 — 19 45 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 28 — 19 45 to July 29 — 19 45

I last saw h.. alive on July 29 19 45; death is said to have occurred on the date stated above, at 6.30 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	
Other Contributory Causes of importance:	
Adv. Atherosclerosis	

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? .....

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Louis Francis M. D.

(Address) 1700 Fortaw Place

If more blanks are needed, address State Registrar, 1315 Eutaw Place, Baltimore, Requesting U. S. No. [illegible]

G31169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31169 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam (Sudilo) SUDILO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known!

8. AGE: Years: About 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sylvester Sudilo
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run Md. G.G. Co.

18 (a) Funeral director John A. Gretkowski Jr
(b) Address 923 S. Paca St.

19 JUL 30 1945 (b) Registrar
(Date received by registrar)

Huntingtown Millersville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 12 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945 to 7/26 1945
and that I last saw him alive on 7/26 1945

Immediate cause of death: Heart failure — Duration 15 min.

Due to Coronary thrombosis — 12 hrs.

Due to Hypertension & Arterio-sclerotic cardiovascular disease — 7 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Vance M.D.
Address John Hopkins Hosp. Date signed 7/27/45

VS 190

PRESS WHITE PLAINLY, WITH DARKENING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G31170

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 439 E. 20th St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 439 E 20th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Troy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1865

8. AGE: Years	Months	Days	If less than one day
80	5		hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Retired tavern keeper

11. Industry or business

FATHER
12. Name John Troy
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss Mary Troy
(b) Address 439 E 20th Street

17 (a) Burial (b) Date thereof 8-1-45
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Balto Md

18 (a) Funeral director Mary M. Keyser
(b) Address E 20th St

(Date rec'd by registrar) JUL 30 1945 Registrar Washington Williamson M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at 9:00 P.M.

21. I ~~certify~~ that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Larynx

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fabrick M.D.
Medical Examiner.
Date signed 7/29/45

X

G31171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248 Registered No. G31171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 W. 20th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Campbell

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1897

8. AGE: Years	Months	Days	If less than one day
47	10	24	hr. min.

9. Birthplace Macon, Ga. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Steve Campbell
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Katie Sanders
15. Birthplace Macon, Ga.

16 (a) Informant Hart Mortuary
(b) Address Macon, Ga.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory
Location Macon, Ga.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JUL 30 1945 (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1945, at 12 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed July 30 1945

Funeral for Wednesday, P.M.

G31172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31172 Registered No. 106 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825-4 St S.W. Wash DC (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Atkin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (town, county, and state or foreign country)

10. Usual Occupation Retired (Grocer)

11. Industry or business

FATHER
12. Name Israel Solomon
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Morris Atkin
(b) Address 1836 G St N.W. Wash DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-45 (month) (day) (year)
(c) Cemetery or crematory Levings Road
Location Washington D.C.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) Registrar

7.31.1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29- 1945 to 7-29 1945 and that I last saw h[illegible] alive on 7-29 1945

Immediate cause of death Cardiac failure & pulmonary edema — Duration

Due to Arteriosclerosis

Due to

Other Conditions Pulm. fibrosis & Emphysema Bronchiectasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac failure & Pulm. Edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Raden M. D.
Address Sinai Hospital Date signed 7/29/45

97

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KREUSINGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31173 / 61

G31173

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G31174

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161c

G31174
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 Trusting Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Edward Tracy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/22/45

8. AGE: Years | Months | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace St Agnes Hospital. Baltimore (City or county), Md (State).

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jos Tracy
13. Birthplace N Y

MOTHER
14. Maiden Name Cecelia Tucker
15. Birthplace Md

16 (a) Informant Sister-in-law.
(b) Address Catonsville City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-45 (month) (day) (year)
(c) Cemetery or crematory Calvert Bapt Mem
Location Bapt Mem

18 (a) Funeral director Geo A Talley
(b) Address Fulton & Fayette Huntington, West Virginia

19 (a) JUL 30 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945 at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945 to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death Cardiac & Respiratory Failure — Duration

Due to Left side, Pneumonia

Due to Probably Erythroblastosis fetalis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Clark M.D.
Address University Hosp. Date signed 7-28-45

VS 150

X

G31175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31175

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Lakeland St
(c) Hospital or institution: West Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Woodhome Harford Co. Black & White Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-25

8. AGE: Years	Months	Days	If less than one day
19 20	7	11	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Webster

13. Birthplace Callaway Va

MOTHER 14. Maiden Name Dove Saul

15. Birthplace Roanoke Va

16 (a) Informant Carl Webster

(b) Address White Hall Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2-45 (month) (day) (year)

(c) Cemetery or crematory Mount Union

Location Callaway Va

18 (a) Funeral director Howard D. Markland

(b) Address White Hall, Md

19 (a) 8-0-1945 (Date received by Registrar) (b) Huntington Mills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30-1945 at 7 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17-1945 to 7-30-1945 and that I last saw him alive on 7-30-1945

Immediate cause of death Respiratory Failure

Due to Paralysis of muscles of respiration

Due to Anterior Poliomyelitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen Curtis Wooden M. D.

Address W.B.G.H. Date signed 7-30-45

G31176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31176 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2800 Annapolis Rd.
(c) Hospital or institution: Westport
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Annapolis Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES KAISS

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13. 1875

8. AGE: Years 70 | Months 2 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Farming

11. Industry or business

FATHER
12. Name John Kaiss
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Schultz
15. Birthplace Germany

16 (a) Informant Charles & Frank Kaiss (Nephews)
(b) Address 2800 Annapolis Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul. 31. 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) (b) (Date received by Registrar) Registrar

JUL 30 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28. 1945 at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945 to July 28 1945 and that I last saw alive on 19

Immediate cause of death: Uremia — Duration: 2 days

Due to: Cardio vascular renal disease — Duration: 12 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. McKinstry M. D.
Address 2470 Mad Blvd Date signed 7-29-45

X

Please write plainly, with unfading ink. Entry must be complete in every space. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G31177
Registered No.

Perfect age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen L. Wieprecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Josephine Wieprecht
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24th 1883

8. AGE: Years	Months	Days	If less than one day
61	7	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Piano Teacher
11. Industry or business

FATHER
12. Name John Wieprecht
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gorski
15. Birthplace Poland

16 (a) Informant Mrs. Josephine Wieprecht
(b) Address 1213 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31st 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgit Road

18 (a) Funeral director Leo S. Lebrun
(b) Address 1701-03 N. Patterson Park Ave

19 (a) 7-31 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27th 1945, at 11:56 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945, to July 27 1945, and that I last saw h.r alive on July 27 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 hrs

Due to Both Varicose Veins

Due to Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald Schneider M. D.
Address 1101 N. Milton Ave Date signed 7-28-45

VS 150

G31178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G31178

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3928 Mortimer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Lovell

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22-1945

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Herbert E Lovell
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma M Yingling
15. Birthplace Maryland

16 (a) Informant Herbert E Lovell
(b) Address 3928 Mortimer Ave, Baltimore Md

17 (a) Burial (b) Date thereof July 31-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pikesville Cemetery
Location Pikesville Md

18 (a) Funeral director H. D. Walther & Sons
(b) Address Union Bridge & Glen Rock Pa

19 (a) (Date received by local registrar) JUL 31 1945 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945, at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to July 30 1945, and that I last saw him alive on July 30 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Enteritis-colitis. Otitis Media	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: 0
of autopsy: Bronchopneumonia + enteritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J Crual Katz M. D.
Address Sinai Hosp Baltimore Md Date signed 7-30-45

G31179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31179

CMK-JO 94779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gustav Raundal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1899

8. AGE: Years	Months	Days	If less than one day
46	1	28	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Machinist-Seaman
11. Industry or business

FATHER
12. Name Tucker Granville
13. Birthplace Norway

MOTHER
14. Maiden Name Inder Oftidal
15. Birthplace Norway

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL JUL 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 31 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16- 1945, at 4:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1945 to July 16, 1945 and that I last saw him alive on July 16, 1945.

Immediate cause of death	Duration
Pulmonary Hemorrhage	2 hr.
Due to: Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balto. City Hosp. Date signed 7/24/45

Please see For: Dr. C. J. Lubinski Approved. Robert H. Gutstein M.D. X
To be approved by the Medical Examiner:

I correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 7 8 2

Registered No. G31180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Redwood
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-43

8. AGE: Years 2 | Months 8 | Days — | If less than one day ____ hr. ____ min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charlie Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name Myadis Coleman
15. Birthplace S.C.

16 (a) Informant Benj Johnson
(b) Address 910 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

vs JUL 31 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26 1945 to 7-30 1945 and that I last saw h. im alive on July 30 1945.

Immediate cause of death Respiratory failure — Duration
a pulmonary edema
Due to Bronchopneumonia, bilateral
Due to Meningeal (?) etiology to be determined
Other Conditions Right sided paralysis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark M. D.
Address University Hospital Date signed 7-30-45

X

G31181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G31181 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Catonsville Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 1960 Belle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Blasy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Blasy 6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) March 9-1878

8. AGE: Years	Months	Days	If less than one day
67	4	25	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation House-Wife

11. Industry or business

FATHER
12. Name John Kramer
13. Birthplace Hungary

MOTHER
14. Maiden Name —
15. Birthplace Hungary

16 (a) Informant John Blasy
(b) Address 1960 Belle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director E. D. Wipperton
(b) Address 1850 W. Baltimore St.

19 (a) ___ (b) Huntington Williams, M.D. Address

Date rec'd by Local Reg. JUL 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1945, to 7/29 1945, and that I last saw h[illegible] alive on 7/29 1945.

Immediate cause of death	Duration
Heart failure	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Date signed 7/29/45

Approved: John R. Davis M.D. per Robert L. Slaton M.D.

G31182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G31182 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution St. Josephs Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 14
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 Hopkins Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George William Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gladys M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/98

8. AGE: Years 47 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Mfgr. Seal

11. Industry or business Industry (Crown, Cork &

FATHER 12. Name George Newton

13. Birthplace England

MOTHER 14. Maiden Name Mary E. Downer

15. Birthplace Virginia

16 (a) Informant Mrs. Gladys M. Newton

(b) Address 300 Hopkins Rd., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 Date AUG 3 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945; at 7:50 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1945 to 7/29 1945, and that I last saw him alive on 7/29 1945;

Immediate cause of death Cardiac failure

Due to Generalized

Due to Carcinomatosis

Co.)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Cyd Jr. M.D.

Address St. Josephs Hosp. Date signed 7/31/45

VS 190

G31183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ D 31183. 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N Washington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N Washington Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Carson White (Kit Carson White)

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 401-28-9903

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: divorced
6 (b) Name of husband or wife: divorced.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1904

8. AGE: Years 41 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Cumberland - Md. (Town, county and state)

10. Usual Occupation shipyard worker

11. Industry or business Bethlehem Shipbuilding Co.

FATHER
12. Name Harrison White
13. Birthplace Cumberland Md

MOTHER
14. Maiden Name Rachel Colclazer
15. Birthplace Partridge Ky.

16 (a) Informant Mrs Margaret [illegible]
(b) Address 107 N Washington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 31 1945 (Date rec'd by Registrar) (b) [illegible] Address

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 7 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 19 45, to 7/27 19 45.
and that I last saw h alive on 7/27 19 45.

Immediate cause of death
Acute Cardiac - Respiratory Failure
Due to Lobar Pneumonia (Primary)
Due to
Other Conditions

Duration
acute
1 wk

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 107 N. Washington Ave Date signed 7/30/45

VS 3

G31184 ✓ G31184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 Brentwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick H Hackett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Frances V
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/1877

8. AGE: Years	Months	Days	If less than one day
68	4	26	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Broker
11. Industry or business

FATHER
12. Name Thomas Hackett
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Ireland

16 (a) Informant Frances V Hackett
(b) Address 1910 Brentwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery or crematory Loud Cathedral
Location Frederick Md

18 (a) Funeral director Edward Fenlon
(b) Address 1913 North Blvd

19 (a) JUL 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 11 30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 28 1945 and that I last saw him alive on July 28 1945

Immediate cause of death Hypertension Cardio-Vascular Renal Disease — Duration 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W P Johnson M.D.
Address 403 Med Arts Bldg Date signed 7-29-45

Supplemented: Robert Lee Graves M.D. 7/31/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G31185 Registered No.

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave Greenspring
(c) Hospital or institution:
Hebrew Home For Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Gwynns Falls Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA COVEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	W.

6 (b) Name of husband or wife Late Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Lith. (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Hyman Silkman
13. Birthplace Russia

MOTHER
14. Maiden Name Freda ?
15. Birthplace Russia

16 (a) Informant Harold Coven
(b) Address 3610 Cedondale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31/45 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tifiloh
Location Windsor Mill Road

18 (a) Funeral director Hol. & Wiseman & Bros.
(b) Address 1124-26 W. North ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150 JUL 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 30 1945 and that I last saw h[illegible] alive on July 30 1945.

Immediate cause of death	Duration
Sarcoma of thigh. Secondary sarcoma in lungs.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin M. D.
Address Lewndale Date signed 7-30-45

X

G31186

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31186
Registered No.

CERTIFICATE OF DEATH 133a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Hgts Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William O. Carneal

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Gertrude Carneal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 - 1871

8. AGE: Years ? 73 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Essex Co. Va
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name William L. Carneal
13. Birthplace Essex Co. Va

MOTHER 14. Maiden Name Jennie Faulkner
15. Birthplace Essex Co. Va

16 (a) Informant Gertrude Carneal
(b) Address 1030 Chesapeake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto. Co. Md.

18 (a) Funeral director Flippin & Flippin
(b) Address 1416 Light St.

19 (a) JUL 31 1945 Registrar for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1945, at 2:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to July 27 1945, and that I last saw h[illegible] alive on July 20 1945.

Immediate cause of death Uremia

Duration: 3 months

Due to pyelonephritis

Due to urinary incontinence

Other Conditions high blood pressure
Cerebral arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. Neubauer, M.D.
M. D.
Address 914 Patapsco Ave. Date signed 7-28-45
Balto. - 25, Md

VS 150

G31187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

✓ G31187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temporary Caroline Ave.
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Westphal Pl. (If rural give location)
(e) Citizen of foreign country? Citizen (Yes or No)
If yes, name country of U.S.

3 (a) FULL NAME Patricia A. McMahon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26-1943

8. AGE: Years	Months	Days	If less than one day
2	0	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael J. McMahon
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Rosemary White
15. Birthplace Baltimore Md.

16 (a) Informant Michael J. McMahon
(b) Address 1631 Westphal Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUL 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1945 to July 29 1945 and that I last saw h. alive on July 29 1945.

Immediate cause of death	Duration
Bilateral Lobar Pneumonia	
Due to Septicemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Rodgers M. D.
Address St. Joseph's Hosp. Date signed 7-29-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92E

G31188

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Warner st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Warner St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Blanche Hall

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	col.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-7887

8. AGE: Years	Months	Days	If less than one day
58	July	3 Dy	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Hodges
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Harris
15. Birthplace Baltimore

16 (a) Informant
(b) Address Odella Morgan

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8 1 45 (month) (day) (year)
(c) Cemetery or crematory Md Calvary
Location a a. co. Md

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W Montgomery St

19 (a) AUG 3 1945 (Delayed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to July 28 1945 and that I last saw h[illegible] alive on July 25 1945.

Immediate cause of death Heart failure

Due to Endocarditis

Due to Dr - Frey

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury female

23. Signature W. Grant Scott M. D.

Address 354 N. Bidle St **Date signed** 7-30-45

VS 3

G31189 25-95057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

✓ G31189 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Race St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irvin Burley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2- 1945

8. AGE: Years	Months	Days	If less than one day
	1	27.	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Willie Johnson
13. Birthplace N.C.

MOTHER
14. Maiden Name Rosa Mae Burley
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July Aug 31 1945 (month) (day) (year)
(c) Cemetery or crematory Jacobsville Md
Location AA. Co. Md.

18 (a) Funeral director Isaiah R Brown Son
(b) Address 1086 Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 31 1945

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29- 1945, at 1.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1945 to 7-29- 1945, and that I last saw him alive on 7-29 1945.

Immediate cause of death Septicemia

Due to Organism not yet identified

Due to

Other Conditions Congenital heart lesion
Malnutrition, Thrush, Diarrhea
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E Barrett M. D.
Address 1204 Date signed 7-30-45

X

G31190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G31190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3043 Stafford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 3043 Stafford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L. Spellissy

3 (b) If veteran, name war none

3 (c) Social Security Account No. 218-05-6711

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia M.

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) June 4- 1915

8. AGE: Years 30 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Chauffer

11. Industry or business Coal

FATHER
12. Name Bernard Spellissy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Sutter
15. Birthplace Baltimore Md

16 (a) Informant Virginia M Spellissy
(b) Address 3043 Stafford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2- 1945 (month) (day) (year)

(c) Cemetery or crematory Western Balto City
Location

18 (a) Funeral director Robt C B.M. Walter
(b) Address Pratt & Stricker Sts

19 JUL 31 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29-45 19 to 7-29-45 19, and that I last saw h i m alive on 7-29-45 19.

Immediate cause of death Cardiac failure — Duration

Due to Malignant Hypertension

Due to Cerebral Vascular Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. S. Temple M. D.
Address 642 Wash. Blvd Date signed 7-31-45

VS 180 To be approved by Medical Exam. OK by Dr Linton by phone on 7-29-45. H. Williams M.D.

G31191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G31191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043 Asquith
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(or City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 Asquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma White Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Married

6 (b) Name of husband ~~or wife~~ Charles Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10-1925

8. AGE: Years	Months	Days	If less than one day
20	2	19	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Domestic

FATHER
12. Name Matthias White
13. Birthplace Md.

MOTHER
14. Maiden Name Dorthy Weaver
15. Birthplace Va

16 (a) Informant Dorthy White
(b) Address 1043 Asquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Md

18 (a) Funeral director Robert Williams
(b) Address 1545 McElderry St

19 (a) Date received (Day) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 4:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1945, to July 29 1945, and that I last saw h alive on July 29, 1945

Immediate cause of death: Pulm Tbc — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Klaus, M. D.
Address 312 E 23rd St Date signed 7-29-45

VS 180

1 of 1
G31192
JO #94844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13C

Registered No. G31192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 W. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Rodgers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1889

8. AGE: Years	Months	Days	If less than one day
56	1	13	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Burrie or Burrell Rodgers (d)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Adelaide ? (d)
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A A Co. Md.

18 (a) Funeral director Arthur Williams
(b) Address 15-15 McElderry

19 (a) JUL 31 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1945, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19, 1945, to July 24, 1945, and that I last saw h. im. alive on July 24, 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 7/25/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G31193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 W. North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Pifferling

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Helen —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-869

8. AGE: Years 75 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Apt. real estate

FATHER
12. Name Seligman Pifferling
13. Birthplace Germany

MOTHER
14. Maiden Name Fannie DeLanhousen
15. Birthplace ?

16 (a) Informant Widow - Helen Pifferling
(b) Address 724 N. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto., Md.

18 (a) Funeral director Chas. Sondheim Co.
(b) Address 1902 Eutaw Place

19 (a) [illegible] (b) [illegible]
(Signature of registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th - 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured third cervical vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 13/2
(a) Date of injury 7-20-45 at 12 Noon M.
(b) Where did injury occur? 724 N. North Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down cellar steps

23. Signature Howard A. Woodside M.D. Medical Examiner.
Date signed 7-30-45

VS 151

G31194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31194 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Berger Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Myers

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Barbara Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 15 1889

8. AGE: Years	Months	Days	If less than one day
56 57	4	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Plumber + steamfitter
11. Industry or business Private business

FATHER
12. Name Conrad Myers
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Margaret Kremer
15. Birthplace Balto Md.

16 (a) Informant Barbara Myers (Wife)
(b) Address 4222 Berger Ave

17 (a) Burial (b) Date thereof Aug. 2. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Hearts Cemt.
Location German Hill road Balto Co

18 (a) Funeral director Lilly & Zeller
(b) Address 403 S Wolfe ST

19 (a) (Date received by registrar) JUL 31 1945 Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1945 to July 30 1945 and that I last saw him alive on July 30 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Adenocarcinoma of sigmoid colon	4 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5/26/45
Major findings of operation: adenocarcinoma of sigmoid colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Milton Tantillo M. D.
Address Mercy Hospital Date signed 7/30/45

VS 150

G31195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G31195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 N. WASHINGTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances R. Bell

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife CHARLES E. BELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 18 1864

8. AGE Years	Months	Days	If less than one day
80 81	11	12	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name WILLIAM H. HEUGELMEIR
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY WEISMAN
15. Birthplace GERMANY

16 (a) Informant CHARLES BELL (SON)
(b) Address 2020 N. WASHINGTON ST.

17 (a) BURIAL (b) Date thereof AUG. 2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly K. Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by Registrar) JUL 31 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1945 at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945 to 9/30 1945 and that I last saw h[illegible] alive on 7/30 1945

Immediate cause of death Pulmonary Embolism

Due to Fracture of left hip

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7/17/45 at 8 A M
(c) Where did injury occur? Home - Bath
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home . While at work?
(Specify type of place)
(e) Means of injury Slipped and fell.

23. Signature [illegible] M.D.
Address [illegible] Date signed 9/30/45

Howard F. Macedo, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hildy

G31196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164C

G31196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 E. Balto. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Lancaster Hampton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 19, 1918

8. AGE: Years	Months	Days	If less than one day
25	7	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Dr. Dewitt B. Lancaster
13. Birthplace Maryland

MOTHER 14. Maiden Name Ada L. Romney
15. Birthplace Maryland

16 (a) Informant MRS. ADA L. LANCASTER
(b) Address 603 CATHEDRAL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-2-45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location BALTIMORE, MD.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19. (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 3 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 12:20 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-29- at 9.15 P.M.
(b) Where did injury occur? 1425 E. Balto St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - revolver

23. Signature Howard A. Mullen M.D. Medical Examiner.
Date signed 7-30-45

G31197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31197 / 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2632 Pennsylvania Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James B. Reed

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 212-09-4189

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed or divorced~~ Married

6 (b) Name of husband or wife Elizabeth A.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 21st, 1885

8. AGE: Years 60 | Months 6 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machanic

11. Industry or business Rheem Co.

FATHER
12. Name James N. Reed
13. Birthplace Unknown

MOTHER
14. Maiden Name Agnes V. Yingling
15. Birthplace Maryland

16 (a) Informant Elizabeth A. Reed
(b) Address 2632 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkwood, Maryland

18 (a) Funeral director Williams, Cook & Dove
(b) Address 1217 St. Paul St.

19 (Date rec'd by registrar) JUL 31 1945 Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 19 45 at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. L. Newcombe M.D.
Medical Examiner.
Date signed 7/30/45

G31198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G31198
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Homestead St
(c) Hospital or institution:
9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Homestead St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella S. Onion

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-21-1872

8. AGE: Years	Months	Days	If less than one day
72	7	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Chase
13. Birthplace Balto Md

MOTHER
14. Maiden Name Margaret Metzler
15. Birthplace Germany

16 (a) Informant James H. Onion
(b) Address 1434 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Date received by local registrar AUG 3 1945 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1/45 19 to 7/31/45, and that I last saw h alive on 7/26/45

Immediate cause of death	Duration
Carcinoma R Lung	6 mos
Due to Carcinoma R Pleura	3 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/4/45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. H. Herrmann M. D.
Address 1710 E 33rd St Date signed 7/31/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

b 3-11-99 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

631199
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: So. Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)

(d) Street No. 2100 Fremont Ave.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Ritterpusch

3 (b) If veteran, name war

3 (c) Social Security Account No. 436-26-9369

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1903

8. AGE: Years 42 Months 3 Days 22 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name L. F. Ritterpusch

13. Birthplace

MOTHER 14. Maiden Name Lanahan

15. Birthplace Baltimore, Md.

16 (a) Informant John F. Ritterpusch-father

(b) Address 525 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Ave.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601-03 East Madison St.

19 (a) [illegible] (b) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1945, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1945, to 7-29 1945 and that I last saw h[illegible] alive on 7-29 1945

Immediate cause of death Bronchopneumonia — Duration

Due to Chronic alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph S. Ardinger

Address 1213 Light St. Date signed 7-29-45 M.D.

VS 156

G31200 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G31200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp 716
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Barber.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Pearlie
6 (c) If alive, give age years
7. Birth date of deceased (mo., da., yr.) March 16 1903
8. AGE: Years 40 | Months 4 | Days 5 | If less than one day hr. min.
9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Barber
13. Birthplace S. C.

MOTHER
14. Maiden Name Lottie McClendon
15. Birthplace S. C.

16 (a) Informant Clifford Godfrey
(b) Address 722 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/45 (month) (day) (year)
(c) Cemetery or crematory Winston Salem
Location Winston Salem N. C.
18 (a) Funeral director Isey & H. Kelson
(b) Address 1303 Pressman St
19 (a) (Date rec'd by Local Reg.) 8-1 1945 (b) Filed Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945, at 7-15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945 to July 30 1945, and that I last saw h[im] alive on July 30 1945.

Immediate cause of death Cerebral Hemorrhage.
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Hoovell M. D.
Address 601 W. Carrollton Ave Date signed 7/3/45
NOVILLE X

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31201

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Barbara Gehring

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1861

8. AGE: Years	Months	Days	If less than one day
84	2	0	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business

FATHER 12. Name Andrew Gehring
13. Birthplace Balto

MOTHER 14. Maiden Name Anna Grunewald
15. Birthplace Balto

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Underfield
(b) Address 914 Greenmount Ave

19 (a) Date received JUL 31 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945, at 4 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945 to July 30 1945, and that I last saw h. E. alive on July 30 1945.

Immediate cause of death Hypostatic pneumonia — Duration 1 day

Due to Myocardiolysis — 1 day

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. H. Deyerle M.D.
Address 928 E North Ave M. D.
Date signed 7/31/45

×

G31202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G31202 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 E.28th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 E 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence C.Piccola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

MOTHER / FATHER
12. Name Wm.E.Callender
13. Birthplace Baltimore Md.
14. Maiden Name Laura Martin
15. Birthplace Baltimore Md.

16 (a) Informant Husband
(b) Address 1910 E.28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1937 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1937, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1937 to July 28 1937 and that I last saw h alive on July 23 1937

Immediate cause of death: Acut Coronary Occ — Duration: 1 day
Due to:
Due to Chron. Myocarditis 5 mos
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C N Mesch M. D.
Address 1570 E. 33rd Date signed 7/30/37

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G31203
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Prince Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME John Hanson Briscoe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1929

8. AGE: Years	Months	Days	If less than one day
16 yrs	6	20	hr. min.

9. Birthplace Prince Frederick, Md.
(Town, county, and state)
10. Usual Occupation Schoolboy
11. Industry or business —

FATHER
12. Name Dr. Everard Briscoe (deceased)
13. Birthplace Prince Frederick, Md.

MOTHER
14. Maiden Name Elizabeth H. Worthington
15. Birthplace Hagerstown, Md.

16 (a) Informant James H. Briscoe (uncle)
(b) Address Prince Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Port Republic, Md.

18 (a) Funeral director A. D. Hankins & Son
(b) Address Mutual, Md.

19 (a) Filed AUG 4 1945 (b) Registrar Huntingtown, Williams, Md.
(Date filed by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1945, at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1945, to 7/30 1945, and that I last saw h) M alive on 7-30 1945.

	Duration
Immediate cause of death Bulbar poliomyelitis	9 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron G. Hull, M.D.
Address Sydenham Hosp. Date signed 7/30/45

X

G31204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G31204 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) Country
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1403 E. Baltimore St. (If rural give location) Corner
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew J. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Wash. Co. Hagerstown Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William J Barnes
13. Birthplace Kemps Mill Md

MOTHER 14. Maiden Name Alice Emmerson
15. Birthplace Falling Waters W. Va.

16 (a) Informant Mrs Batt
(b) Address Hagerstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/45 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md.

18 (a) Funeral director A. K. Coffman
(b) Address Hagerstown Md.

19 Filed AUG 1 - 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 7-30 at 4:15 P.M. 4/1
(b) Where did injury occur? City Harbor - ft of Fallsway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Drowning

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed

VS 151

B 31205 X B 31205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Gray Manor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Parkwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Mathena

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-28-45

8. AGE: Years 0 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Raymond Mathena
13. Birthplace W. Va.

MOTHER 14. Maiden Name Inez Warnick
15. Birthplace W Va

16. (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 45 (month) (day) (year)
(c) Cemetery or crematory Pipes Cem
Location Princeton West Va

18. (a) Funeral director Selby & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) AUG 2 1945 (Local registrar's) Huntington, W. Va. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to July 31 1945 and that I last saw h alive on July 31 1945.

Immediate cause of death Respiratory Failure — Duration

Due to otitis media — Duration

Due to Parenteral diarrhea — Duration

Other Conditions Congenital Syphilis — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Emmett Batson, M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/1/45

Shepperson

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G31206

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3905 BARRINGTON RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 37 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3905 BARRINGTON RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE OLIVER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife ALEX

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name LEO
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

19 (a) AUG 1 - 1945 (Date received by registrar)

Hunting for Hillcrest Mem.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31-45 19 , at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to July 31 1945, and that I last saw her alive on 7-31 1942.

Immediate cause of death Hyper nephroma — Duration 2½ years

Due to

Due to

Other Conditions Terminal Broncho pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 7/31/45

X

G31207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150 C

G31207 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HUBBARD & GREEN
(c) Hospital or institution: UNIV. HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION F GREEN F 30026

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 1, 1927

8. AGE: Years	Months	Days	If less than one day
17	9	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Walter Green
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Jennings
15. Birthplace Md

16 (a) Informant Lillian Green
(b) Address 825 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-45 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral Location Baltimore

18 (a) Funeral director Jos. L. Chase Son
(b) Address 638 N. Eutaw St

19 (a) (b) Registrar
(Date rec'd by registrar)

AUG 1 - 1945

vs 150

Huntington Hillsdale, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1945 at 4:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1945 to 7-30 1945, and that I last saw h[illegible] alive on 7-30 1945.

Immediate cause of death: Respiratory failure — Duration
Due to Acute pulmonary edema
Due to 1) Aspiration vomitus
2) Pre-eclampsia
Other Conditions: Full term preg. delivered
Fulminating pre-eclampsia
(Include pregnancy within 3 months of death)
Date of operation 7-29-45
Major findings of operation: Full term living male child
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Norment III M.D.
Address Univ Hosp Date signed 7-30-45

R. B. NORMENT 3rd

G31208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31208 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 Vine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah L. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1873

8. AGE: Years 72 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Boston
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name
15. Birthplace Baltimore, Md.

16 (a) Informant M's Gladys Dowsey
(b) Address 760 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Jesse Ruddem
(b) Address 436 S. Bidder St

19 (a) Filed AUG 1 - 1945 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1945 19 , at 12:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1945, to July 30 1945, and that I last saw her alive on 29 1945

	Duration
Immediate cause of death Cardio Pulmonary Disease	2 wks
Due to Hypertension	2 yrs
Due to Cirrhosis Sclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Wallace Frey M. D.
Address 1928 Penna Ave. Date signed 7/31/45

X

D 31209. ✓ D 31209.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 677 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 677 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Groves

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	widowed

6 (b) Name of husband or wife John A. Groves (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-1881

8. AGE: Years	Months	Days	If less than one day
63	10	20	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Derry
13. Birthplace Md.

MOTHER
14. Maiden Name Charlotte Carells
15. Birthplace Md

16 (a) Informant C. Naomi Davidson
(b) Address 677 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co Md

18 (a) Funeral director Bayard Magruder Wright
(b) Address 727 Cathedral St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 AUG 1 - 1945

Huntington Williams, MD

Rayner Browne

MEDICAL CERTIFICATION

20. DATE OF DEATH 7.30 1945 at 1.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to 7.30 1945 and that I last saw her alive on 7.27 1945

Immediate cause of death: Valvular insufficiency (Aortic + Mitral) — Duration: 11 yrs+

Due to

Due to

Other Conditions: Hypertensive cardio-renal disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1500 E. Madison St Date signed 8/1/45

G31210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G31210 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Staunton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife Richard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1879

8. AGE: Years	Months	Days	If less than one day hr.	min.
65 66	7	-		

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles H. Giles
13. Birthplace Havre de Grace, Md.

MOTHER
14. Maiden Name Johanna Griggs
15. Birthplace Havre de Grace, Md.

16 (a) Informant Margaret Stokes
(b) Address 2507 Madison Ave.

17 (a) Burial (b) Date thereof Aug. 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. D.R.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George W. Hulland
(b) Address 1631 Druid Hill Ave

19 (a) AUG 1 - 1945 Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-1945; at 11:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-23-1945 to 7-25-1945, and that I last saw h[illegible] alive on 3-28-1945

Immediate cause of death	Duration
Chronic Nephritis	
Due to Uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Hutton M.D.
Address 1631 Druid Hill Ave
Date signed 8/1/45

Huntington Williams, M.D.

G31211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G31211
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Benjamin Simonds

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Mollie Virginia Simonds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1863

8. AGE: Years	Months	Days	If less than one day
81	10	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired - City Employee

11. Industry or business

FATHER
12. Name Unknown Simonds
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Pearl Knapp
(b) Address 1716 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 1 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30. 1945 at 10:10 a.m.

21. I certify that death occurred on the date above stated, that I attended deceased from May 19 45 to July 30 19 45
and that I last saw h alive on 19

Immediate cause of death: Bronchial pneumonia — Duration: 2 wks
Due to: Chronic Bronchitis — 2 yrs
Due to:
Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D.
M. D.
Address 127 S. Charles St. Date signed

VS 150

7/31/45

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G31212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. G31212

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Witherspoon Rd, (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Robert Lee Hearn

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Heller Hearn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 19, 1873

8. AGE: Years 72 | Months 4 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace: Maryland. (Howard Co.) (Town, county, and state)

10. Usual Occupation: Wholesale fruit+produce

11. Industry or business

FATHER
12. Name: Chas. Hearn (d)
13. Birthplace: Maryland.

MOTHER
14. Maiden Name: Elizabeth Feinour
15. Birthplace: Maryland.

16 (a) Informant: Mrs. Ruth H. Hearn
(b) Address: 203 Witherspoon Rd., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Mausoleum
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) ... (b) Huntington Williams, M.D. Registrar
(Date received by registrar) AUG 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1945, to July 29 1945. and that I last saw h[illegible] alive on 7-29 1945.

Immediate cause of death: Cerebrovascular accident — Duration:
Due to: arteriosclerosis.
Due to:
Other Conditions: (Hemiparesis resulting)
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: L. D. Lippincott, Jr. M. D.
Address: Union Memorial Date signed 7-29

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G31213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170B

✓ G31213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bryan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archibald Lopp

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	176-07-8087	male	white	Married

6 (b) Name of husband or wife Goldie Lopp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1907

8. AGE: Years	Months	Days	If less than one day
38	1	8	hr. min.

9. Birthplace Morgan Co. W.Va.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Joseph Lopp
13. Birthplace W.Va.

MOTHER
14. Maiden Name Amanda Bernhard
15. Birthplace W. Va.

16 (a) Informant Mrs. Goldie Lopp - Widow
(b) Address 2131 Harford Road

17 (a) Burial (b) Date thereof 8/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location Gettysburg, Pa.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 AUG 1 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 50

20. DATE OF DEATH July 30, 1945 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Pelvis
Ruptured Urinary Bladder
Acute Congestive Cardiac
Dyspnea Failure

Other Conditions Fractured 6th rib, laceration, bruises and brush burns
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-29-45 at 12/4 1 A. M.
(b) Where did injury occur? St. Paul & 20th Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Auto & street car Collision

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 7-31-45

VS 151

G31214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ G31214

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Both Physicians and Undertakers are required by law to fill out correctly all items on this certificate. Physicians: please write the causes of death clearly and legibly. Be sure that age is correctly stated. Be sure that the cause of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD HENRY PFUND

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 219-01-9140

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Magdalena Hahn
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1870

8. AGE: Years	Months	Days	If less than one day
74	10	8	hr. min.

9. Birthplace Philadelphia, Pa (Town, county, and state)
10. Usual Occupation TReas. Balto. Press Club
11. Industry or business

FATHER
12. Name Jacob Pfund
13. Birthplace Germany

MOTHER
14. Maiden Name Christine ?
15. Birthplace Germany

16 (a) Informant John Edward Pfund
(b) Address Howard Henry Pfund

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 1 1945 (b) Hunting to Millersville Md
Received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1945, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945 to 7/29 1945, and that I last saw h alive on 7/29 1945

Immediate cause of death: Hemoplegia Apoplectus — Duration 12hrs

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wright A. Dudley, M. D.
Address 3376 E. Balto St Date signed 7/30/45

X

G31215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156a

G31215 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 S. Curley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Curley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ermatowski (Filipowicz)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1910

8. AGE: Years	Months	Days	If less than one day
34	8	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Ermatowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Dix
15. Birthplace Poland

16 (a) Informant Mrs. Zofia Filipowicz
(b) Address 13 S. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 3 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Webber
(b) Address 401 S. Chester Street

19 AUG 1 - 1945 (b) Huntington Williamson, W. Va.

VS 150

MEDICAL CERTIFICATION 11.15

20. DATE OF DEATH July 30 /45 19 , at P. M

21. I certify that death occurred on the date above stated that I attended deceased from July 19 42 to July 30 1945 and that I last saw him alive on July 30 1945.

Immediate cause of death — I
Infection
Due to Carbuncle Generalized
Due to
Other Conditions Pul Embolism
(Include pregnancy within 3 months of death)

Duration: 4 hrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Patterson Park Ave Date signed 8-1-45

G31216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1477

G31216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 W Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1112 W Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

S33023

3 (a) FULL NAME Helen Coates Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Austin Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/29/01

8. AGE: Years 70 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edw. Doshiell
13. Birthplace Balto Md

MOTHER
14. Maiden Name Belle Grayson
15. Birthplace Balto Md

16 (a) Informant Austin Johnson
(b) Address 1112 W Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie A Williams
(b) Address 322 N Schroeder St.

AUG 1 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1945 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27 19 to 7/28 1945 and that I last saw h[illegible] alive on 7/28 1945

Immediate cause of death Pulmonary Embolism (Puerperal)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hemy Baldcore M. D.
Address 1131 Hollins St Date signed 7/31/45

VS 150

G31217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G31217

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 E Madison
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Brown Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Colored	Married

6 (b) Name of husband or wife Rufus Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Joshua Brown
13. Birthplace Balto

MOTHER 14. Maiden Name Amanda Scott
15. Birthplace Md

16 (a) Informant Elizabeth Lee
(b) Address 1596 E Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn A.A.Co. Md.

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E Jefferson St.

AUG 1 - 1945 (Date rec'd Registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945, at 6:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1945 to July 30 1945; and that I last saw h[illegible] alive on July 29 1945.

Immediate cause of death Mitral Insuff'ency — Duration 5 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Fisher M.D.
Address 1612 E Monument Date signed July 31 1945

G31218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G31218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3324 Eagleside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 Eagleside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

17

3 (a) FULL NAME Samuel Joseph Roche

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-2300

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret Shyrock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1887

8. AGE: Years	Months	Days	If less than one day
57	11	21	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Sylvester J. Roche
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Johanna Ryan
15. Birthplace Ireland

16 (a) Informant Sylvester J. Roche
(b) Address 3324 Eagleside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory St. Margaret's Church
Location Govans, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Reisterstown Rd

AUG 1 - 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to July 29, 1945, and that I last saw him alive on July 28, 1945.

Immediate cause of death	Duration
Extravasation	1 week
Due to Carcinomas of Lung	2 Mo
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) ~~Manner of injury~~, Edward J. Wells

23. Signature X Wells
Address 5276 Park Heights Ave Date signed July 30 45 (M. D.)

G31219

CLARK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3317 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3323 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret D. Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife Edward P. Clark
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	12	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home.

FATHER
12. Name Carl Zang
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Bamera
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 3317 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 AUG 1 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 45 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 19 45 to July 31 19 45 and that I last saw h alive on July 30 19 45.

Immediate cause of death Heart failure — Duration
Due to Coronary artery disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Franklin E. Zeiler, M. D.
Address 1115 St Paul Date signed July 31, 1945

Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

VS 150

G31220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G31220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 13, 1906

8. AGE: Years	Months	Days	If less than one day
39	6	18	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Peet Shapiro
13. Birthplace Austria

MOTHER
14. Maiden Name Fannie Levy
15. Birthplace Austria

16 (a) Informant Maurice H Miller
(b) Address 1713 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 AUG 1 - 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1945, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to Aug 1 1945 and that I last saw her alive on Aug 1 1945

Immediate cause of death	Duration
Metastases To the lungs	
Due to Carcinoma of the Breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L Rosenthal M. D.
Address Sinai Hospital Date signed Aug 1 1945

VS 190

X

G31221

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √ 55E

G31221 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Ky.~~ Va (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Edwards St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Ray Wheeler
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-22-43

8. AGE: Years	Months	Days	If less than one day
2	1	9	hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James William Wheeler
13. Birthplace Ky.

MOTHER
14. Maiden Name Martha Parsons
15. Birthplace Ky.

16 (a) Informant Records (b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/1/45 (month) (day) (year)
(c) Cemetery ~~or~~ Forest Lawn Cemetery Location Norfolk, Va.
18 (a) Funeral director John Whitehill & Sons Inc. (b) Address 1900 Eutaw Place
19 AUG 1 - 1945 Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 31 1945, at 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 30 1945 to July - 31 1945 and that I last saw him alive on July - 31 1945

Immediate cause of death Resp. failure — Duration
Due to Malnutrition
Due to Retinoblastoma of right eye
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. F. Brown
Address John Hopkins Hosp. Date signed 8-7-45

VS 150

G31222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G31222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4405 Kenwick Rd
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 5½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4405 Kenwick Rd (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Lily Edna MacLean

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Fredk. W. MacLean
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 21 1872

8. AGE: Years 72 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace St Martin - N.B. Can.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Wm F. Rourke
13. Birthplace Canada

MOTHER
14. Maiden Name Rachael Vaughan
15. Birthplace Canada

16 (a) Informant Mr Ronald F. MacLean (son)
(b) Address 4405 Kenwick Rd

17 (a) burial (b) Date thereof 8-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Sherwood Memorial Co.
(b) Address 108 W Mt Vernon

19 AUG 1 - 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar) Address 140 E Pacific Date signed 7/31/45

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to July 31 1945
and that I last saw him alive on July 30 1945

Immediate cause of death: Carcinoma (Ovary) — Duration 2-3 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Moody, M.D.

Please write plainly, with pen; use no abbreviations. Physicians: please write the cause of death clearly and legibly. Information required is especially important. Physicians: please write the cause of death clearly and legibly.

VS 180

G31223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3423 Paton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3423 Paton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26-1896

8. AGE: Years	Months	Days	If less than one day
49	4	19	hr. min.

9. Birthplace St. James- Jamaca B. W. I.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Grace Johnson
(b) Address 3423 Paton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-45 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Baltimore Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 117 N. Carrollton Ave

AUG 1 - 1945 (Date rec'd) (b) Huntington Nitkin (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at 7.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to July 31 1945, and that I last saw him alive on July 30 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Chronic Myocarditis	
Due to Endocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N. Carrollton Ave Date signed 8/1/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G31224

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Grazier Bottom.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Reece.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-26-74.

8. AGE: Years	Months	Days	If less than one day
71	5	5	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Farmer.

11. Industry or business

FATHER
12. Name Sam Reece.
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Va.

16 (a) Informant Raymond.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-1-45 (month) (day) (year)
(c) Cemetery or crematory Winfield
Location Winfield, W. Va.

18 (a) Funeral director Williams Coale & Son
(b) Address 1217 St. Paul St.

19 (a) 1945 (Date filed by registrar) (b) Number by registrar Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1945 at 1.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945, to August 1 1945, and that I last saw him alive on Aug 1 1945.

Immediate cause of death: hepatic insufficiency
Cachexia

Due to: Carcinoma - Head of the Pancreas

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Dickson Jr. M.D.
Address Johns Hopkins Hospital. Date signed 8/1/45

Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31225

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31225 Registered No. 469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1446 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET E. MAHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1877

8. AGE Years	Months	Days	If less than one day
67	9	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Sewing Machine Operator
11. Industry or business

FATHER
12. Name John J. Maher
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice M. Nelson
15. Birthplace Maryland

16 (a) Informant Mrs. Georgia Hopkins
(b) Address 1446 N. Gay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Jr. Huntington Williams, Mgr.
(b) Address 1217 St. Paul Street

AUG 1 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945 to July 30 1945 and that I last saw her alive on July 30 1945.

Immediate cause of death	Duration
Uremia	24 hrs.
Due to Carcinoma of breast	3 mos.
Due to	over
Other Conditions Hypoglycemia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A. Horn, M.D. M. D.
Address 4212 Kelly Avenue Date signed 7/31/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLUCK

G31226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G31226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Marigold
(b) Street address 810 Marigold St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto city
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Marigold St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Pluck

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-18-0385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2 - 1921

8. AGE: Years	Months	Days	If less than one day
23	8	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Operator Factory

11. Industry or business

FATHER
12. Name Wm C. Pluck
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rena Menster
15. Birthplace Balto Md.

16 (a) Informant Mrs Rena Pluck
(b) Address 810 Marigold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3. 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Bernard G Funk
(b) Address 3603 Belair Rd.

19 AUG 1 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 5:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1945 to July 30 1945, and that I last saw him alive on July 29 1945.

Immediate cause of death (a) Pulmonary Tuberculosis — Duration 1 Year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schofield M.D.

Address 2301 Druid Park Dr. Date signed 8-3-45

VS 150

G31227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G31227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 245 Dallas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3 192[illegible]

8. AGE: Years	Months	Days	If less than one day
24	4	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace ..

MOTHER 14. Maiden Name Unknown

15. Birthplace ..

16 (a) Informant Viola Bell

(b) Address 245 Dallas ct

17 (a) Burial (b) Date thereof 8/1/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy A Wilson

(b) Address 1000 Belmont Ave

19 (a) (b)
(Signature of registrar) Huntington Williams M.D.

GI 1945
VS 1ST

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 12 15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Forster M.D.
Medical Examiner.

Date signed July 28 1945

X

G31228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 E Chauncey Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 E Chauncey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Lodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Harry Lodman
(b) Address 825 Chauncey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jacob Aquila Inc
(b) Address 1349 E. Baltimore St

19 (a) (Date received by registrar) (b) Registrar

AUG 1 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31- 1945 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 45 to July 31 1945, and that I last saw h[illegible] alive on July 30 1945.

Immediate cause of death: Myocardial Insufficiency
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/1/45

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G31229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31229 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5701 Rockspring Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Rockspring Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Erastus Franck

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
X	X	Male	White	Married

6 (b) Name of husband or wife XXX
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name Charles E. Franck
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Brant
15. Birthplace Maryland

16 (a) Informant Mrs. Emily A. Franck
(b) Address 5701 Rockspring Road

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3707 W. North Ave.
19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 1:30

20. DATE OF DEATH July 31 1945, at A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943 to July 31 1945 and that I last saw him alive on July 30 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to Generalized arterio-sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R. Hantz M. D.
Address 2601 Maryland Ave. Date signed 7/31/45

VS 150

AUG

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

G31230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G31230

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr, 11days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Hugo Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Christina Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	married

6 (b) Name of husband or wife Mr. William A. Stevenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/91

8. AGE: Years	Months	Days	If less than one day
54	4	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Yuhn
13. Birthplace Chee

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant William A Stevenson
(b) Address 2717 Hugo Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Randall E Humphreys
(b) Address 1401 N. Broadway

19 (a) (Date rec'd by Local Registrar) AUG 2 1945 (b) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23/1945 to 7/31/1945, and that I last saw h[illegible] alive on 7/31/1945

Immediate cause of death

Due to Metastatic

Due to Carcinoma of

Other Conditions pneumonia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. P. Hodges M. D.
Address St. Joseph's Hosp. Date signed 7/31/45

G31231

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 46E

CERTIFICATE OF DEATH

G31231 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Relay (If outside city or town limits, write RURAL and give town)
(d) Street No. 5000 Tulip Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laurence S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-94

8. AGE: Years 50 | Months 9 | Days 23 | If less than one day hr. min. 51

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Heuisler

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Jenkins

15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 3-1945 (month) (day) (year)

(c) Cemetery or crematory GREENMOUNT

Location

18 (a) Funeral director Chas. J. Grogan Son Inc

(b) Address 118 N. Mt. Royal Ave

19 (a) (b) Registrar

Filed AUG 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to July 30 1945 and that I last saw him alive on July 30 1945.

Immediate cause of death Hepatic Coma

Due to Carcinoma of colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.

Address Johns Hopkins Hosp. Date signed 8-1 1945

Huntington Williams, M.D.

G31232 ✓ G31232

JO #94564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Fred Evans

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife ?
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	22	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name John Evans (d)
13. Birthplace ?

MOTHER
14. Maiden Name Annie ? (d)
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Frances A. Hennessey
(b) Address 521 W. Baltimore St.

19 (a) AUG 2 - 1945 (Registered by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1945, to July 31, 1945, and that I last saw him alive on July 30, 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to uremia	
Due to glomerulonephritis - arteriolarsclerotic	
Other Conditions pneumonia, lobar	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Jonathan Howland M. D.
Address BCH Date signed 8/1/45

VS 150

X

G31233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G31233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 E Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teodozja Matija MATEJA

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Ignatius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Gulowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Stefan Matija
(b) Address 1728 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Frank W Czaszewski
(b) Address 1900 Eastern Ave

19 (a) Date received by Local Registrar AUG 2 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/30 1945 to 7/31 1945 and that I last saw h[illegible] alive on 7/31 1945

Immediate cause of death Chronic Hypertension Uremia Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mitchell J. Kurkowski M. D.

Address 1076 S. Ellwood Ave Date signed

MITCH KURKOWSKI X 8/2/45

477 631234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

631234 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Laurens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Chester Samuel Hurt.
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-2964

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Annie May.
6 (c) If alive, give age 39. years

7. Birth date of deceased (mo., day, yr.) September 1, 1900

8. AGE: Years	Months	Days	If less than one day
44, ~~45~~	10	28	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Shipyard - worker.
11. Industry or business

FATHER
12. Name Allen Hurt.
13. Birthplace Va.

MOTHER
14. Maiden Name Isabella Crowley.
15. Birthplace Va.

16 (a) Informant Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 4. 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Co. Md

18 (a) Funeral director Joseph A. Lively
(b) Address 1101 Mount St. Baltimore Md

19 (a) Aug 2 - 1945 Huntington W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July. 29 1945 at 9. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July. 17 1945, to July. 29 1945, and that I last saw him alive on July. 29 1945.

Immediate cause of death Uremia — Duration

Due to Nephrosclerosis

Due to

Other Conditions Hypertensive, arteriosclerotic Ht. disease; Cong. F.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 7/30/45

G31235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G31235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 N. Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/1927

8. AGE: Years 18 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Geo. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Lucille Johnson
15. Birthplace 2425 Howard St.

16 (a) Informant Lucille Johnson
(b) Address 2425 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 AUG 2 - 1945 (b) Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH July 29, 1945; at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Stab wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11:20 P.M. 7-29-45
(b) Where did injury occur? in front of 2216 N. Howard St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Stabbed

23. Signature Howard J. Moreau M.D.
Medical Examiner.
Date signed 7-30-45

VS 151

G31236

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G31236
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 Mc Henry St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Mc Henry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Hoffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife George Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1898

8. AGE: Years	Months	Days	If less than one day
47	-	12	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William F. Rhynechi
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Baraba ?
15. Birthplace Balto. Md.

16 (a) Informant Melvin M. Hoffman
(b) Address 915 Mc Henry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Robert Brooks & Son
(b) Address Calhoun & Hollins St.

19 (a) AUG 2 - 1945 (b) Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1st, 1945, at 8:25 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereof and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-1-45

1237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G31237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 S. Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena M. Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1860

8. AGE: Years	Months	Days	If less than one day
85	5	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Housewife

FATHER
12. Name John Reitz
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Flemming
(b) Address 2521 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3-45 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer
Location

18 (a) Funeral director Charles P. Towell
(b) Address 2427 Edmondson Ave.

AUG 2 - 1945 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1st 1945 at 7:45 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maddox M.D.
Medical Examiner.
Date signed 7-1-45

VS 151

G31238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G31238 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Poplar Grove St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William Russell Keller.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25-1900

8. AGE: Years	Months	Days	If less than one day
44	11	6	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Electrical Engineer
11. Industry or business Construction Work.

FATHER
12. Name Clayton R. Keller
13. Birthplace Md

MOTHER
14. Maiden Name Katherine Nolan
15. Birthplace Md

16 (a) Informant Mr. Clayton R. Keller
(b) Address 1511 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 45 (month) (day) (year)
(c) Cemetery or crematory Loraine Cem
Location Woodlawn Md

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 1512 Hollins St

19 (a) (date received by Local Registrar) (b)
AUG 2 1945
Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1943, to 7-31-1945, and that I last saw him alive on 7-30-1945.

Immediate cause of death	Duration
Exhaustion from malnutrition	6 mo.
Due to Tuberculosis of tongue	6 mo.
Due to Tuberculosis of lungs (Chronic)	?
Other Conditions Peri-anal abscess + sinus	7 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice L. Shannon M. D.
Address 3300 N. Charles St Date signed 8/1/45

X

G31239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G31239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hill
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Horace Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1911
8. AGE: Years 34 Months 1 Days If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Rose Taylor
(b) Address 1613 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Leg. B. Kelaar
(b) Address 1313 Pennsylvania Ave Huntington Woodlawn, Md

19 (a) AUG 2 — 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30- 1945, at 11:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27- 1945 to 7-30 1945, and that I last saw h alive on 7-30- 1945

Immediate cause of death Chronic Valvular Heart Disease — Duration 2 mos

Due to

Due to

Other Conditions Hemiplegia — Duration 2 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page, M.D.
Address 1516 N. Mount St (17) Date signed 8-2-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31240

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G31241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Bradshaw (If outside city or town limits, write RURAL and give town)
(d) Street No. Midway Inn (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Joseph Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Separated

6 (b) Name of husband or wife Eleanor Henry Dorsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13-1904

8. AGE: Years 40 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Phila. (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Midway Inn.

FATHER 12. Name Charles Dorsey

13. Birthplace England

MOTHER 14. Maiden Name Sarah Sivell

15. Birthplace Phila.

16 (a) Informant Mrs. Charles Dorsey

(b) Address 6024 Schisler St. Phila. Pa.

17 (a) Transportation (burial, cremation, or removal) (b) Date thereof Aug 2-45 (month) (day) (year)

(c) Cemetery or crematory

Location Phila, Pa.

18 (a) Funeral director John J. Connelly

(b) Address 4 E Baltimore Ave. Darby

19 (a) (Date) AUG 2 1945 Huntington Williams, Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1945, at 2 25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull, avulsion of Brain
Fractured Ribs

Due to

Other Conditions Fracture - Laceration, bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-1-45 at 1:10 P.M.

(b) Where did injury occur? Rt. 40 - in front of Midway Inn Balto Co.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Pedestrian Struck by truck.

23. Signature Howard J. Mc Sherry, M.D. Medical Examiner.

Date signed 8-1-45

VS 151

31242 BONTKOWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G31242 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Bethel St
(c) Hospital or institution: 410 S. Bethel St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Bethel St (If rural give location)
(e) Citizen of foreign country? Poland. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bontkowski

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months - | Days - | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Woodworker

11. Industry or business

FATHER
12. Name Stephen Bontkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Rozalia Kaminska
15. Birthplace Polans

16 (a) Informant Mary Bontkowski
(b) Address 410 S. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location City Limits

18 (a) Funeral director Wm. F. Gallagher
(b) Address 1618 Eastern Ave

19 (a) AUG 2 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1945 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1945 to 7/31 1945 and that I last saw h[illegible] alive on 7/31 1945

Immediate cause of death Carcinoma of Rectum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Kenworthy M. D.
Address 1915 East Ave Date signed 8/2/45

VS 150

G31243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G31243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie B. Douglin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Jos. F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-1865

8. AGE: Years	Months	Days	If less than one day
76	9	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Meyer
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Weigner
15. Birthplace Md

16 (a) Informant Mrs. Margaret E. Sarent
(b) Address 705 Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Leonard & Keen
(b) Address 5305 Harford Rd

19 (a) Registrar (b) Arlington Millinery MD

AUG 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to July 29 1945; and that I last saw her alive on July 29 1945.

Immediate cause of death Cerebral hemorrhage — Duration 2 days
Due to Hypertension
Due to Arteriosclerosis
Other Conditions Senile degeneration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. V. Harbold M. D.
Address 4706 Harford Road signed 7/31/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G31244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Dukeland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Dukeland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Katherine A. Clayland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	married

6 (b) Name of husband or wife Daniel L. Clayland.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/1872

8. AGE: Years	Months	Days	If less than one day
72	11	—	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home. Wife

11. Industry or business

FATHER
12. Name Wm. Feeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Raymond
15. Birthplace Ireland

16 (a) Informant Mr. D. L. Clayland
(b) Address 2123 Dukeland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Loudon Park

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 318 Light St.

19 (a) Date received AUG 2 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1945, to July 31 1945, and that I last saw h alive on July 29 1945.

Immediate cause of death Carcinoma uterus with Metastases — Duration 1 yr.

Due to

Due to

Other Conditions Hypertension Coronary Dis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. A. Darby M. D.
Address 817 Medical Arts Bldg. Date signed Aug 4/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G31245 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 W. Lafayette

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d

(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits write RURAL and give town)

(d) Street No. 1514 W. Lafayette

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lillie Bordley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife Walter Bordley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-1894

8. AGE: Years	Months	Days	If less than one day
51	1	17	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Jacob Chapman

13. Birthplace Va

MOTHER 14. Maiden Name Eliza Jones

15. Birthplace Va

16 (a) Informant Emma Tinder

(b) Address 514 W Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-43 (month) (day) (year)

(c) Cemetery or crematory Dulaney Memorial

Location Balto Co

18 (a) Funeral director Sam'l R. Chase & Son

(b) Address 538 N. Eutaw

19 (a) AUG 2 - 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1943 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1943 to July 31 1943 and that I last saw her alive on July 31 1943.

Immediate cause of death Lobar Pneumonia

Duration 3 Days

Due to Cancer of Breast 6 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. A. Pifer M.D.

Address 1336 W. Lanvale St. Date signed 8-2-43

VS 150

G31246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G31246 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luella Lola Sherrills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Golden Sherills

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 3, 1885

8. AGE: Years 59 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Hueston, Texas (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Mack Hill

13. Birthplace Texas

MOTHER 14. Maiden Name Tempie Mitchel

15. Birthplace Texas

16 (a) Informant Blanche Hardy

(b) Address 1236 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Elroy C. Wilson

(b) Address 1000 Brantley Ave

19 (a) (Date received by registrar) AUG 2 1945 (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945 at 8 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to July 31 1945, and that I last saw h-- alive on July 31 1945

Immediate cause of death Carcinoma of Liver — Duration 2

Due to

Due to

Other Conditions Myocardial Degeneration, Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Jacobs

Address 617 North Pk Road Date signed M D 8/1/45

X

G31247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

G31247 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5704 Kenner Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? ~~Yes or~~ No)
If yes, name country

3 (a) FULL NAME Annie M. Shipley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 18 [illegible]

8. AGE: Years	Months	Days	If less than one day
85	9	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Regin Shipley
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Margaret Fells
15. Birthplace Carroll Co Md

16 (a) Informant Mrs Aileen Kirkland
(b) Address 5704 Kenner Ave

17 (a) Burial (b) Date thereof 8-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Forney Byers
(b) Address 5005 Harford Ave

19 (a) AUG 2 1946 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1946, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945 to July 31 1945, and that I last saw her alive on July 31 1945

Immediate cause of death Congestive Heart failure — Duration 3 days
Due to Mitral insufficiency — 2 yrs
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R Bloom, M. D.
Address 401 Manhattan Ave
Date signed 8/2/46

X

G31248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

G31248 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 810 S. Linwood St.

(If rural give location)

(e) Citizen of foreign country? (~~Yes~~ or No)

If yes, name country

3 (a) FULL NAME Benjamin Rakowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-8957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband or wife~~ Alvina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 1898

8. AGE: Years	Months	Days	If less than one day
47	-	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER

12. Name Caesar

13. Birthplace Poland

MOTHER

14. Maiden Name Catherine

15. Birthplace Poland

16 (a) Informant Alvina Rakowski

(b) Address 810 S Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)

(c) Cemetery or crematory Ft Standaus

Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2429 Hudson St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 2 1945

Va Tbo

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31 1945, at 2:26 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1945 to 7/31 1945 and that I last saw h (~~a~~)live on 7/31 1945.

Immediate cause of death	Duration
Cardiac failure	
Pulmonary Edema	
Due to Squamous Cell Ca of Penis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. D. Ellis Jr M.D.

Address St Agnes Hosp Date signed 8/1/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4780 G31249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G31249
Registered No.

Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ronald Jarvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-21-45

8. AGE: Years	Months	Days	If less than one day
	3	11	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russell Jarvis
13. Birthplace Ky.

MOTHER
14. Maiden Name Pauline Falin
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3 /45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave

18 (a) Funeral director John O. Mitchell Sons Co
(b) Address 1900 Eutaw Place.

19 (a) [illegible] by registrar) Huntington Williams, M.D.
(b) Date received Aug 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2. 1945 at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945, to Aug. 2 1945, and that I last saw him alive on Aug. 2 1945.

Immediate cause of death	Duration
Circulatory + respiratory collapse	
Due to acute nutritional disturbance	
Due to atrophy of liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond M. D.
Address Johns Hopkins Hos. Date signed 8/2/45

G31250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31250

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2246 Brookfield Ave.
(c) Hospital or institution:
none

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 Brookfield Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie W. Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife John C. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1860

8. AGE: Years	Months	Days	If less than one day
84	11	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Francis M. Denny
13. Birthplace Royal Oak, Md.

MOTHER
14. Maiden Name Henrietta K. Hughes
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marion D. Hewes
(b) Address 2246 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Rec'd by registrar

1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1, 1945, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Aug 1 1945
and that I last saw her alive on Aug 1 1945

Immediate cause of death Myocardetis
Arteio-Sclerosis — Duration Greater

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Roadley M. D.
Address 1403 Park Ave. Date signed Aug 2-45

X

G31251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G31251 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 Highland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Highland Ave Bklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline E. Lehmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Otto Lehmann
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 30, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name August Schuster
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Hilda Lemmon
(b) Address 427 Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon P/L
Location Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 716 Light St

19 (a) 1945 (b) Registered by registrar Washington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to July 31 1945, and that I last saw her alive on July 31 1945.

Immediate cause of death Coronary heart disease

Due to

Due to

Other Conditions Diabetes arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 208 Calhoun Date signed

VS 150

94a

G31252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G31252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Stiles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Hector Stiles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1903.

8. AGE: Years	Months	Days	If less than one day
42	1	20	hr. min.

9. Birthplace E. New York (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Walker
13. Birthplace New York

MOTHER
14. Maiden Name Maude Steinbrant
15. Birthplace New York

16 (a) Informant Hector Stiles
(b) Address 5208 Gonam ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 1945 (month) (day) (year)
(c) Cemetery or crematory St Matthias
Location Adamell St

18 (a) Funeral director Wendell Hippel
(b) Address 312 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) Registration District

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1945 at 11:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial degeneration

Other Conditions Extreme obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D. Medical Examiner.
Date signed July 29 1945

52 vs 1945

G31253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

✓ G31253 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dollis Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Coldfop Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-45

8. AGE: Years | Months: 4 | Days: 26 | If less than one day: hr. min.

9. Birthplace Balto. md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Purnell Hopkins

FATHER 13. Birthplace

MOTHER 14. Maiden Name Delores Coles

MOTHER 15. Birthplace Balto. md.

16 (a) Informant Mrs Delores Hopkins

(b) Address 107 Coldfop way

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 2 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918- Druid Hill Ave,

19 (a) 8-2-1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1945 at 2 P M 35

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7/28/45 M.

(b) Where did injury occur? 107 Coldfop Way Sollis R. md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury ACCIDENTALLY DROPPED WHILE

23. Signature Office Exp. Physician M.D. Medical Examiner.

Date signed July 29 1945

VS 151

G31254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G31254
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Lafayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Erdman Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	~~M~~ W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name John Emerenzauer
13. Birthplace Pa

MOTHER
14. Maiden Name Catherine Eby
15. Birthplace Pa

16 (a) Informant Mrs Harry Hafner
(b) Address 3509 Erdman ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 3 (month) (day) (year)
(c) Cemetery or crematory Middletown Cem
Location Middletown Pa

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 3 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1945, at 1 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1945, to 8-1 1945, and that I last saw h~~im~~er alive on 8-1 1945.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to	
Due to	
Other Conditions ① Diabetes ② Post reduction fracture of rt hip	

(Include pregnancy within 3 months of death)

Date of operation 7-20 & 7-25-45

Major findings of operation: Treat subcut neck of femur - pinned

of autopsy: neg findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 7-12-45 at a M
(c) Where did injury occur? Balto (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell to floor at home

23. Signature H. K. Kerzelman M D M. D.
Address Franklin Sq Hosp Date signed 8-1-45

For H. S. McNally, M.D. - Howard J. Kerzelman, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G31255 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Wendover Rd.
(c) Hospital or institution:

12-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Wendover Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RUEIL KEEDY GREITZNER RICE

3 (b) If veteran, name war: W.W. #1

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Edna Grace Smith Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1899

8. AGE: Years	Months	Days	If less than one day
45	9	20	hr. min.

9. Birthplace Keddysville Maryland (Town, county, and state)
10. Usual Occupation General Agent
11. Industry or business Equitable Life of Iowa

FATHER
12. Name Rev. Samuel L. Rice
13. Birthplace Va.

MOTHER
14. Maiden Name Mary M. Shank
15. Birthplace Va.

16 (a) Informant Mrs. Edna Grace Rice
(b) Address 212 Wendover Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Evergreen Cemetery
Location Gettysburg Pa.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address North & Pennsylvania Aves., Baltimore, Md.

19 (a) (b) Registrar

(Date rec'd by registrar) AUG 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1945, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 8/2 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Occlusion	1 Hour
Due to Coronary Sclerosis	?
Due to Hypertension (Untreated)	2 years
Other Conditions Obesity	6 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hershey M. D.
Address 714 Medical Let Bldg Date signed 8/3/45

Huntington Williams Howard J. Mercer, M. D.

G31256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G31256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archer Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-2642

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1907

8. AGE: Years 38 | Months | Days | If less than one day: hr. min.

9. Birthplace Bluefield W. Va.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Geo. Wash. Henderson
13. Birthplace N. C.

MOTHER
14. Maiden Name Martha Mims
15. Birthplace N. C.

16 (a) Informant Mrs Mary Smith
(b) Address 1205 Pfeiffer Ave.

17 (a) Burial **(b) Date thereof** 8-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. Halstead

18 (a) Funeral director
(b) Address 918 Druid Hill Ave.

19 (a) AUG 3 1945 **(b)** Huntington Williams
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1945, at 5:35 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of thorax

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-26-45 at M.
(b) Where did injury occur? 1340 Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public **While at work?** No
(d) Means of injury Stabbed

23. Signature Roland La Fontaine M.D.
Medical Examiner.
Date signed July 29 1945

VS 151

G31257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31257 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 Forrest Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Effie Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Chas. Walker
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace Suffolk, Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Domestic

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Oreda Perry
15. Birthplace unknown

16 (a) Informant Chas. Walker
(b) Address 149 - High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 - Lloyd Hall Ave.

19 (a) AUG 2 (Date rec'd by registrar) (b) 1945 Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29, 1945, at 7 45 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute dilatation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 29 1945

VS 151

G31258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1496

G31258

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts.

(c) Hospital or institution: Mercy Hospital 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore # 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1016 Brentwood Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME Mrs. Elsie Beauchamp G29447

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife W. J. Beauchamp

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Nov 15 - 1910

8. AGE: Years 34 | Months 8 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Philadelphia, Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER

12. Name William Vieth

13. Birthplace Germany

MOTHER

14. Maiden Name Jenny Miller

15. Birthplace Philadelphia, Pa

16 (a) Informant Deceased before death

(b) Address See above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5-45 (month) (day) (year)

(c) Cemetery or crematory Henderson Cem.

Location Hyacinth Va.

18 (a) Funeral director Wm Cook Inc.

(b) Address 1217 St Paul St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/45 1945 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 5:00 PM 8/1/45 to 2:30 PM 8/2 1945, and that I last saw her alive on 8/2 1945.

	Duration
Immediate cause of death Peripheral Vasc. Collapse	3½ hrs
Due to Cardiac failure & shock	3½ hrs
Due to Delivery of 40 wks pregnancy	40 wks
Other Conditions None	over

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature A. F. A. Stedem Jr

Address Mercy Hosp. Date signed M 8 D 2/45

AUG 3 1945

X

G31259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G31259
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City morgue
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Onofrio Di Carlo

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 9 17 14-0694

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Desiarda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 14 1879

8. AGE: Years 65 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Casacalenda, Italy
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Nicola Di Carlo
13. Birthplace Italy

MOTHER
14. Maiden Name Rosalia Margarello
15. Birthplace Italy

16 (a) Informant Desiarda Di Carlo
(b) Address 126 Market Place

17 (a) Burial (b) Date thereof 8-6-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd., Balto. Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 W. Hoffman St.

19 (a) AUG 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Cardio-vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maldeis M.D.
Medical Examiner.
Date signed 8-2-45

VS 151

G31260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G31260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ladland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 284 Dallas Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Comba

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/44

8. AGE: Years	Months	Days	If less than one day
	11	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carter Comba
13. Birthplace Cleveland Va

MOTHER
14. Maiden Name Madyna Kenlener
15. Birthplace Cleveland Va

16 (a) Informant Carter Comba
(b) Address 284 Dallas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-45 (month) (day) (year)

(c) Cemetery or crematory Finney Va
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1496 Balto St

19 (a) AUG 7 1945 Registered. (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1945, at 6:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 2 1945 and that I last saw h[illegible] alive on Aug 2 1945.

Immediate cause of death	Duration
Shock and toxemia	
Due to Second degree burns of entire body	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-2-45 at A. M
(c) Where did injury occur? 284 Dallas Court (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Scalded in tub

23. Signature Marion Rudo M. D.
Address Sinai Hospital Date signed 8/4/45

Approved: Hugh B. Cuskaly M.D. per Robert Lee Gutsch M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 CARSWELL STREET
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 YRS. 9 MO., 2 DA

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 CARSWELL ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA JOHANN KIRKLEY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	WIDOWED

6 (b) Name of husband or wife EDWARD T. KIRKLEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 31, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	2	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name JOHN REESE
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINE MOHLER
15. Birthplace GERMANY

16 (a) Informant CHARLES KIRKLEY
(b) Address 1429 CARSWELL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL CEM.
Location RICHIE HIGHWAY

18 (a) Funeral director Walter Burke Beatty
(b) Address 1922 W. NORTH AVE.

19 (a) (b)

AUG 3 1945 Huntington Williams, MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2nd 1945, at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to Aug 2nd 1945, and that I last saw h[illegible] alive on aug 1 1945.

Duration
Immediate cause of death Myocardial insufficiency.
Due to arterio sclerotic hypertrophy and dis. with hypertrophy and congestive heart failure.
Due to Generalized arterio sclerosis with hypertension.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. O. Michel M. D.
Address 2901 Edmondson Date signed Aug 3 1945.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G31262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5714 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Myra Dubble Archibald.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Albert R. Archibald.
6 (c) If alive, give age 69. years

7. Birth date of deceased (mo., day, yr.) April 29, 1881

8. AGE: Years	Months	Days	If less than one day
64	3	3	hr. min.

9. Birthplace Norwich N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edwin Libbee
13. Birthplace Homerville, N.Y.

MOTHER
14. Maiden Name L. Hubbard.
15. Birthplace Norwich, N.Y.

16 (a) Informant Mr. Albert R. Archibald
(b) Address 5714 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 3 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1945 at 6.28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/ 1945 to 8/2 1945, and that I last saw her alive on 8/2 1945

Immediate cause of death Respiratory failure
Anemia

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy:

Duration
post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. T. Brindle M.D.
Address Mercy Hospital Date signed 8/2/45

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

VS 150

G31263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31263 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calhoun St
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2511 Queen Anne Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sunderland - Elizabeth Brown

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 217-01-3176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1873

8. AGE: Years	Months	Days	If less than one day
71	8	9	hr. min.

9. Birthplace Anne Arundel County (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Addison Owens
13. Birthplace Anne Arundel Co - Md

MOTHER
14. Maiden Name Florence E. Elliott
15. Birthplace Prince George Co - Md

16 (a) Informant Franklin Square Hosp
(b) Address N Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 3 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1945, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945, to Aug 3 1945, and that I last saw h[illegible] alive on Aug 2 1945.

Immediate cause of death: Coll Bladder Disease — Duration: 7 days
Due to
Due to
Other Conditions: Diabetes mell
Coma. & Hypostatic Congestion — Duration: 1
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Dreyfuss, M.D.
Address 817 Medical Arts Bldg. Date signed Aug 3 1945

127B

G31267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G31264

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 S. Streeper
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN KAMISICI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Augusta B. Ozeh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1894

8. AGE: Years	Months	Days	If less than one day
51		20	hr. min.

9. Birthplace Poland (town, county, and state)

10. Usual Occupation Patrolman

11. Industry or business Baltimore Police

FATHER
12. Name August
13. Birthplace Poland

MOTHER
14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Wife
(b) Address 641 S. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7-45 (month) (day) (year)

(c) Cemetery or crematory Pennsylvania
Location Donnell Pk

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N Broadway

19 (a) AUG 3 1945 (b) Huntington, W.Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/45 19 , at 1:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.

Date signed 8/3/45

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G31265 2 G31265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1233 N. Ellwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 N. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella May Shackelford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Harry A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1871

8. AGE: Years	Months	Days	If less than one day
73	6	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Hiram Kimball
13. Birthplace Baltimore

MOTHER
14. Maiden Name not known
15. Birthplace Baltimore

16 (a) Informant Mrs. Marie Amass
(b) Address 1233 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) AUG 3 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1, 1945 19 , at 5pM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to July 31 1945, and that I last saw her alive on July 31 1945.

Immediate cause of death Gangarine right foot — Duration 2 mos
Due to Diabetes Mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Baumgardner M.D.
Address Balto 6 Date signed 8/2/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G31266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sydenham Hospital
(c) Hospital or institution: Herring Run
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 4
(e) Length of stay in Baltimore (yrs., mos., or days) 13 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 773 W. Lexington St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Betty Jane Turner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16, 1944

8. AGE: Years	Months	Days	If less than one day
1	~~13~~ 1	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Noah Turner
13. Birthplace Hardy County, W. Va.

MOTHER
14. Maiden Name Nellie Rose
15. Birthplace Hardy County, W. Va.

16 (a) Informant Nellie Turner
(b) Address 773 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Peru
Location Hardy County, W. Va.

18 (a) Funeral director Miller Lawrence
(b) Address 1003 W. Baltimore St.

19 (a) AUG 3 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945, to 8/2 1945, and that I last saw her alive on 8/2 1945.

Immediate cause of death Unknown
Fever of unknown origin — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration over

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H D Smith M. D.
Address Sydenham Hosp. Date signed 8-2-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31267 ✓ G31267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Ferndale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Ferndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Irma Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James Edward Brown
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) March 6, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	25	____ hr. ____ min.

9. Birthplace Morrillton, Arkansas (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Bevely Edward Green
13. Birthplace Tennessee

MOTHER
14. Maiden Name Murtha Daleska Magruder
15. Birthplace Richmond, Va.

16 (a) Informant Mr. Haines B. Felter
(b) Address 3707 Hillsdale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4520 Liberty Heights Ave.

19 (a) AUG 3 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1945, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1945, to 8/1 1945, and that I last saw her alive on 8/1 1945.

Immediate cause of death (a) Pneumonia (Bilateral) — Duration 11 days
Due to
Due to
Other Conditions Chronic Nephritis — 3 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Carroll M. D.
Address 3902 Groveland Ave. Date signed 8/2/45

X

VS 3

G31268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G31268

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 156
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Clavier Ave., 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. H. Benjamin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Gogie Benjamin
6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) 10/9/1865

8. AGE: Years	Months	Days	If less than one day
79	9	24	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Benjamin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Maryland

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6/1945 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Gettysburg Pa.

18 (a) Funeral director Harry M. Annarose
(b) Address 4204 Ridgewood Ave

19 (a) [illegible] (b) Huntington Williams M.D. (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-45 19..., at 4.08 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-1945 to 8-3-1945, and that I last saw her alive on 8-3-45

Immediate cause of death	Duration
Coronary occlusion with Myocardial infarction	
Due to Arteriosclerotic Heart disease	
Due to Arteriosclerosis, General	
Other Conditions Hypertension Cardio-vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Lord III M. D.
Address Union Memorial Hosp Date signed 8-3-45

VS 150

G31269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31269
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD AVE.
(c) Hospital or institution:
CONVALESENCE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) 3.MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County Frederick
(c) City or town FREDRICK MARYLAND
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME BETTY E. KEENAN.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Andrew J. Keenan
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1864

8. AGE: Years	Months	Days	If less than one day
80	11	25	hr. min.

9. Birthplace Loudon Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Everhart
13. Birthplace Virginia

MOTHER
14. Maiden Name Susie Nair
15. Birthplace Virginia

16 (a) Informant Andrew J. Keenan
(b) Address 2704 Kennedy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4. 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 1 1945 19 , at 5.A.M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 31 1945 to AUG 1 1945, and that I last saw h or alive on AUG 1 1945.

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION.	JULY 31 .45
Due to CHRONIC MYOCARDITIS	1944.
Due to ARTERIOR SCLEROSIS	1944.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. F. Blantice M. D.
Address 3013 ST PAUL ST Date signed AUGUST 1 1945.

G31270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G31270

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hospital St. Agnes Hospital

(c) Hospital or institution Shelling & Caton Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Wilmington Ave. Morrell Park
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-45

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Oscar Elmer Hall
13. Birthplace Mockville, N. C.

MOTHER
14. Maiden Name Evelyn O'Brien
15. Birthplace Granville, N. C.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-45 (month) (day) (year)

(c) Cemetery or crematory Baptist Cemetery
Location Stovall N. Carolina

18 (a) Funeral director John C. Miller Inc

(b) Address 2435 E. Oliver St.

19 (a) (Date received by Registrar) (b) Registrar

AUG 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945 at 7:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945 to 8/5 1945 and that I last saw him alive on Aug 5 1945.

	Duration
Immediate cause of death Cardiac Failure	
Due to Congenital Heart Disease (Tetralogy of Fallot)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. A. D. Blair Jr M.D.

Address St Agnes Hosp Date signed Aug 7 1945

X F.W.S.

G31271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G31271
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 W. Lanvale St
(c) Hospital or institution:

16-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Ball (HAMLETT)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-3-1903

8. AGE: Years 42 | Months 4 | Days 25 | If less than one day 29 hr. min.

9. Birthplace Lancaster Va (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business Domestic

FATHER 12. Name Eddie Tomlin

13. Birthplace Va

MOTHER 14. Maiden Name Sallie Ball

15. Birthplace Va

16 (a) Informant Helena Tomlin Pitts

(b) Address 1029 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 5 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director Williams & Jackson

(b) Address 916 Penna ave

19 (a) 8 4 1945 (Date rec'd by local Registrar) (b) Huntington Williams, M.D. Registrar

AUG 4

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1945 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1945 to Aug 2 1945; and that I last saw her alive on Aug 2 1945.

Immediate cause of death

(a) Nephritis Chronic Combined Renal-Vascular

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 mo 2 dy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Hatcher M. D.

Address 1225 Pa Ave Date signed Aug 4

VS 150

G31272

CHK-94940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G31272

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 88- 7- 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Robinson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Raither

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary Raither (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1857

8. AGE: Years	Months	Days	If less than one day
88	7	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name Casper Raither (D)
13. Birthplace ? Germany

MOTHER
14. Maiden Name Crystal Disher
15. Birthplace ? Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue Aug 4 '45

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) 4110 Reisterstown Rd

19 (a) AUG 4 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 1 1945, at 12:30M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945, to Aug. 1 1945, and that I last saw him alive on Aug. 1 1945.

	Duration
Immediate cause of death: Bronchopneumonia, bilateral	1 wk.
Due to	
Due to: Urinary retention; Prostatic hypertrophy	
Other Conditions: Acute epididymitis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address B'more Date signed 8-3-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G31273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 Overland ave
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 & 2
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Overland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William H. Watt

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-1299

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 - 1903

8. AGE: Years	Months	Days	If less than one day
42	3	23	hr. min.

9. Birthplace England (town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Ship yard

FATHER
12. Name Samuel Watt
13. Birthplace England

MOTHER
14. Maiden Name Mary H Payne
15. Birthplace England

16 (a) Informant Mrs John Fornish
(b) Address 2828 Overland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2908 Arlington Ave

19 (a) AUG 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-45 19 to 8-3-45 19 and that I last saw him alive on 8-3-45 19

	Duration
Immediate cause of death Cardio Respiratory Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-1-45
Major findings of operation: Carcinoma
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Wallace M. D.
Address 1400 N. Caroline St Date signed 8-3-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31274 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution St. Josephs Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 Overland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Watt Watt.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/74

8. AGE: Years 70 | Months 9 | Days 10 25 | If less than one day hr. min.

9. Birthplace England (town, county, and state)

10. Usual Occupation Janitor
11. Industry or business Public Schools

FATHER
12. Name John Watt
13. Birthplace England

MOTHER
14. Maiden Name Dont Know
15. Birthplace England

16 (a) Informant Mrs. Ruby Forsith
(b) Address 2828 Overlandave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulerich Funeral Home
(b) Address 2008 Arlington Ave

19 (a) Filed AUG 4 - 1945 (b) Registrar Huntington Williams, M.D.
Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1 1945 6:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1945 to 8/1 1945 and that I last saw h[illegible] alive on 8/1 1945.

Immediate cause of death: Cardio-respiratory failure. — Duration
Due to Uro-nephritis
Due to Pneumonia
Other Conditions Fractured nose. Fractured 2nd, 3rd & 4th ribs left
(Including pregnancy within three months of death)
Date of operation
Major findings of operation: Bilateral pneumonia. Enlarged gall bladder. Enlarged prostate
of autopsy Nephritis. Enlarged prostate

PHYSICIAN
Underlying cause to which death should be charged

22. If death was due to external causes fill in the following: 9/9
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6/27/45 M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At school #20 While at work
(Specify type of place)
(e) Means of injury Fell off bridge

23. Signature Frank H. Lloyd Jr.
Address St. Josephs Hospital Date signed 8/1/45
Howard J. Clemens, M.D.

VS 150

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G31275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G31275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence B. Ritchie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Edda Mae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-1871

8. AGE: Years	Months	Days	If less than one day
74	4	7	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name John S. Ritchie
13. Birthplace D.C.

MOTHER
14. Maiden Name Mary S. Gidmore
15. Birthplace ?

16 (a) Informant Clarence C. Ritchie
(b) Address 3117 Brendan Rd.

17 (a) Burial (b) Date thereof 8-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Wm. Cook Jr.
(b) Address 217 St. Paul St.

19 (d) AUG 4 - 1945 Huntington W. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2- 1945, at 2 5-5 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured skull
Fractured Cervical Vertebra

Due to

Other Conditions Fractured ribs.
Cer. arteriosclerosis + Coronary Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-2- at 1:30 P.M.
(b) Where did injury occur? Front of 2419 Fairview Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? yes
(d) Means of injury: While painting, fell from scaffold

23. Signature Howard J. Clemens M.D.
Medical Examiner.
Date signed 8-3-45

VS 151

G31276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31276 Registered No. 463

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Wk
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 N. Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Thomas J. Brooks (Thomas J. Brooks)

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-05-2562

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ----- -----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1891

8. AGE: Years 53 | Months 9 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation General BENCH Hand

11. Industry or business LUMBER MILL

FATHER
12. Name Thomas Brooks
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Foley
15. Birthplace Ireland

16 (a) Informant Mr. John W. Brooks (Brother)
(b) Address 4504 Mary Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location 4430 Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date) (b) (Registrar) AUG 4 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-45 19 ..., at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1945, to 8-3 1945, and that I last saw h[illegible] alive on 8-3 19 45

Immediate cause of death Carcinoma Ileo Cecal — Duration

Due to Ca of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Williams M. D.
Address 1400 N. Caroline St. Date signed 8-3-45

VS 150

X

G31277 BRAIN ✓ G31277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3145 Stafford St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Francis J. Braun.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2nd Apr 1896

8. AGE: Years 48 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Mc Laughlin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Hudson
15. Birthplace Ireland

16 (a) Informant Frank J. Braun
(b) Address 3145 Stafford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6th 1945 (month) (day) (year)
(c) Cemetery or crematory Bethedal
Location Baltimore Md.

18 (a) Funeral director Dill Bros.
(b) Address 3109 Frederick Ave.

19 (Certificate received by registrar) AUG 4 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/ 1945, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8/2 1945 and that I last saw h[illegible] alive on 8/2 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rewitt, Jr. M.D.
Address St. Agnes Hospital Date signed 8/2/45

VS 150

X

G31278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Jeffrey St.
(c) Hospital or institution: Jeffrey St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 Fairhaven (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pete Saravanos

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64	1		hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16. (a) Informant August Conomos
(b) Address 126 Meadow Road.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Greek Evangelical
Location Baltimore, Md

18 (a) Funeral director John J. Mullen
(b) Address 2236 Jefferson St.

19. Date rec'd by local registrar AUG 4 1945 Registrar Huntington Wilkerson, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walders M.D. Medical Examiner.
Date signed 8-2-45

X

G31279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31279

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3614 Plateau Ave
(c) Hospital or institution:

28 1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Plateau Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Busick Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0263

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence L Pryor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1889

8. AGE: Years 56 | Months 1 | Days 16 15 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Standard Oil Co

FATHER
12. Name George Henry Pryor
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emma Teresa Busick
15. Birthplace Baltimore Md.

16 (a) Informant Florence L. Pryor
(b) Address 3614 Plateau Ave

17 (a) Burial (b) Date thereof Aug 6 1940
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Harry A Annarett
(b) Address 4204 Pedgewood Ave

19 (a) AUG 4 (b) 1940
(Date received by Registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1940, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1940 to 8-3 1940, and that I last saw h alive on 8-3 1940.

Immediate cause of death Coronary Thrombosis — Duration 2 Hrs

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J Q'Hara M.D.
Address 4039 Liberty Heights Ave Signed 8-3-

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

631280 631280

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N. Curley St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME LeRoy Epperson

If U. S. Veteran specify WAR

(a) Residence: No. 27 N. Curley St., 6-1 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna A

6. DATE OF BIRTH (month, day, year): Jan. 2-1905

7. AGE: 40 Years | Months 7 | Days - | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): West Va

FATHER

13. NAME: Jim Epperson

14. BIRTHPLACE (city or town) (State or country): West. Va.

MOTHER

15. MAIDEN NAME: Sarah Spivey

16. BIRTHPLACE (city or town) (State or country): West. Va.

17. INFORMANT: Anna A. Epperson

(Address) 27 N. Curley St

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date Aug 6- 1945

19. UNDERTAKER: John A. Hoffman

(Address) 3000 E. Baltimore St.

20. FILED AUG 4 - 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Aug 2, 1945

22. I HEREBY CERTIFY, That I attended deceased from July 10, 1945, to Aug 1, 1945

I last saw h[illegible] alive on Aug 1, 1945. Death is said to have occurred on the date stated above, at 2 45 AM.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma	
of Stomach	1-yr

Other contributory causes of importance:

Ulcer of	2-yr
Stomach	

Was an operation performed? Yes Date of

For what disease or injury? Carcinoma of

Name of operation removal of Stomach

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) [signature] M. D.

(Address) 2901 Eastern Ave

OCCUPATION is very important. See instructions on back of certificate.

VS 3

Schaub

G31281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G31281 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 South Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edward A. Schaub

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13-1888

8. AGE: Years	Months	Days	If less than one day
56 5/7	8	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Schaub
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Byrnes
15. Birthplace Ireland

16 (a) Informant Mary M. Schaub
(b) Address 401 S Augusta

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (month) (day) (year)
(c) Cemetery or crematory New Cath.
Location Old Frederick Rd

18 (a) Funeral director John J. Ingram
(b) Address 3600 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 4

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1945, at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1945 to 8/2 1945, and that I last saw him alive on 8/2 1945

Immediate cause of death Coronary thrombosis
C Congestive failure.
Due to Hypertension cardio vascular disease.
Due to
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Nephrosclerosis

Duration
12 days.
(?)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Schaffer M. D.
Address Bon Secours Hosp. Date signed 8/2/45

X

G31282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316 G31[illegible]

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Fair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Isabelle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1903

8. AGE: Years 42 | Months —5 | Days —7 | If less than one day hr. min.

9. Birthplace Huntington W. Va. (Town, county, and state)

10. Usual Occupation Self Employed

11. Industry or business Fair

FATHER
12. Name John
13. Birthplace Georgia

MOTHER
14. Maiden Name McKenzie
15. Birthplace

16 (a) Informant Isabelle Fair
(b) Address 923 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Orbut Lawn Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. A. Copeland
(b) Address 1600 Druid Hill Ave

19 (a) AUG 4 - 1945 (Date rec'd by registrar) Registrar

Huntington, W. Virginia, U.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1/45 19 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12/45 19 to 7/19/45 and that I last saw h alive on 19

Immediate cause of death Pulmonary Embolism

Due to Cystitis

Due to Cystitis

Other Conditions V

(Include pregnancy within 3 months of death)

Date of operation V

Major findings of operation: V

of autopsy: V

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Barksdale M. D.
Address 536 N. Carey St. (Physician signing) 7/19/45

M. Barksdale

VS 190

042546 G31283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G31283
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G31284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2110 E. Biddle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frank Arnold Sr

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-3192

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Henrietta

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 6-1870

8. AGE: Years	Months	Days	If less than one day
74 ~~65~~	7	17 16	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business J. J. Stainmaker

FATHER — 12. Name Henry Arnold
13. Birthplace G

MOTHER — 14. Maiden Name Elizabeth Schmidt
15. Birthplace Balto

16 (a) Informant Charles Arnold Jr
(b) Address 2110 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Baltimore Md

18 (a) Funeral director D. J. Stevenson
(b) Address 3001 Pentwater Ave

19 AUG 4 - 1945 (Date rec'd by registrar) (b) Huntington Pittsburgh Pa

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1945 at 10 A.M 35

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slater M.D. Medical Examiner.
Date signed August 2 1945

VS 151

G31285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1633 Thomas
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) over

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Thomas
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN I TROBAUGH

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 214-12-9342

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Luella Lee Trobaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1883

8. AGE: Years 62 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation ###### Cabinet Maker

11. Industry or business Beth. Fairfield Co.

FATHER
12. Name John Trobaugh
13. Birthplace Va.

MOTHER
14. Maiden Name Mary---
15. Birthplace Va.

16 (a) Informant Mrs. Luella Lee Trobaugh
(b) Address 1633 Thomas Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Green Hill Cem.
Location Martinsburg West Va.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 (a) AUG 4 1945 Lington Williamson

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/45 19 at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry) to the death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 8/4/45

G31286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G31286 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson 4, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 E. Joppa Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of ~~husband~~ or wife Marion A. Williams
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	6 5	— hr. — min.

9. Birthplace Brewster, Mass. (Town, county, and state)
10. Usual Occupation night watchman
11. Industry or business Goucher College, Towson

FATHER
12. Name Judah F. Perry
13. Birthplace Mass.

MOTHER
14. Maiden Name Lyda A. Sears
15. Birthplace Mass

16 (a) Informant Mrs. Alzada P. Ruhl
(b) Address Timonium, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Parkville, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 AUG 4 1945 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945, at 7 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945, to Aug. 4 1945, and that I last saw him alive on Aug. 3 1945

	Duration
Immediate cause of death cerebral hemorrhage	3 days
Due to arteria-sclerotic heart disease	
Due to	
Other Conditions post-operative cholecystectomy (Include pregnancy within 3 months of death)	
Date of operation July 20, 1945	
Major findings of operation: acute gangrenous cholecystitis & cholelithiasis	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M. D.
Address Union Memorial Hosp Date signed Aug 7, 45

VS 150

X

G31287 ZANT G31287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58E

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 E Fayette St
(c) Hospital or institution:
5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 E Fayette St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Zant

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 8th 1913

8. AGE: Years 30 | Months 1 | Days 13 | If less than one day — hr. — min.

9. Birthplace Bluffton S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Cesar Zant
13. Birthplace S. C.

MOTHER
14. Maiden Name Bessie Lawton
15. Birthplace S. C.

16 (a) Informant Bessie Zant
(b) Address 1433 E Eutaw Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. G. County

18 (a) Funeral director Byron & Manning Wright
(b) Address 721 Ensworth St.

19 AUG 4 - 1945 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1st 1945; at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to Aug 1 1945 and that I last saw h — alive on July 31st 1945.

Immediate cause of death	Duration
Rheumatic fever	3 days
Due to	
Due to acute dilitation of the heart	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward E. Fisher M.D.

Address 1612 E. Monument St. Date signed 8-3-45

VS 180

1612 E. Monument St X

G31288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G31288

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 3014 Mosher St. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Anna Higdon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-16-9692

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Bernard Higdon
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) April 26, 1909

8. AGE: Years	Months	Days	If less than one day
36	3	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Carroll
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Ellershinch
15. Birthplace Germany

16 (a) Informant Mr. Bernard Higdon
(b) Address 3014 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 1214 N. Charles St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 2 1945
and that I last saw h alive on Aug 1 1945

Immediate cause of death	Duration
Primary Edema Larynx	3 hrs.
Due to Cy Liver	1 Hr.
Due to	
Other Conditions	

(Include pregnancy within three months of death)
Date of operation —
Major findings of operation:
of autopsy: Cy Liver — Ca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholas J. Gonella, M.D.
Address 617 Hamford Rd Date signed 8/3/45

G31289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G31289

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [illegible] Birkenwald (Essie)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Pike
13. Birthplace Virginia

MOTHER
14. Maiden Name Jeannie Jacobson
15. Birthplace Virginia

16 (a) Informant Mrs. Simon Hamm
(b) Address Epsmonian Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/45 (month) (day) (year)
(c) Cemetery Hebrew Friendship
Location Waste, Md.

18 (a) Funeral director David Sonnenstein & Son
(b) Address 1902 Eastern Place

19 (a) Date received AUG 4 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945, to Aug 3 1945, and that I last saw h[illegible] alive on Aug 3 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchiogenic Carcinoma of lung with pleural effusion	
Due to	
Other Conditions Congestive heart failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hospital Date signed 8/3/45 M. D.

VS 150

X

G31290 Pembroke

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G31290

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-H
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward K. Pembroke
3 (b) If veteran, name war No
3 (c) Social Security Account No. 205-05-3865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Jennie Pembroke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-7-1888

8. AGE: Years	Months	Days	If less than one day
57	7	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name William Pembroke
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Pembroke
15. Birthplace Md.

16 (a) Informant Jennie Pembroke
(b) Address 908 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director C. Kas. P. Lees
(b) Address 802 Mad. Ave.

19 AUG 4 - 1945 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1-45 19 , at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1- 1945 to 8-1- 1945 and that I last saw him alive on 8-1-45 19

Immediate cause of death	Duration
Cardiac failure	
Due to Mitral Stenosis	2 yrs.
Due to Rheumatic Fever	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis E. Hamm M. D.
Address 2340 Madison Ave. Date signed 8-3-45

VS 150

X

G31291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G31291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2029 N. Calvert Street.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elaine Ann Means

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-19-1945

8. AGE: Years 0 | Months 1 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Robert LeRoy Means
13. Birthplace West Virginia

MOTHER
14. Maiden Name Deloris M. Martin
15. Birthplace Washington, D. C.

16 (a) Informant Mr. Robert L. Means (father)
(b) Address 2029 N. Calvert Street, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-5-1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

1945 Aug 4 (b) Huntington, W. Va.
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1945, at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1945 to 8/4 1945
and that I last saw h____ alive on 8/3 1945

Immediate cause of death: Hydrocephalus — Duration: 6 wks
Due to
Due to
Other Conditions: Spina bifida
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2020 Clarey Date signed 8/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G31292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31292

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 10. (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park apts. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Merle Robert Meacham

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Edythe T. Meacham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1887

8. AGE: Years	Months	Days	If less than one day
57	7	19	hr. min.

9. Birthplace Randolph, Ohio (Town, county, and state)
10. Usual Occupation Mgr.
11. Industry or business Standard Oil Co.

FATHER
12. Name Ira Meacham
13. Birthplace Ohio

MOTHER
14. Maiden Name Ella Carver
15. Birthplace Ohio

16 (a) Informant Mrs. Merle R. Meacham
(b) Address Roland Park apts, City 10.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/5/45 (month) (day) (year)
(c) Cemetery or crematory Ravanna
Location Ravanna, Ohio

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (d) AUG 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1945, at 5.10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30/1945, to 8/3/1945, and that I last saw him alive on 8/3/1945

Immediate cause of death	Duration
Cardiac failure	
Due to Cerebral hemorrhage	9 days
Due to Hypertensive C-V disease	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Methuselah Spragues
Address U. M. H. Date signed 8-5-45

VS 150

G31293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G31293 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fulton & Eutaw

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3313 Liberty Hgts Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Turner Ashby Miller, Jr.

3 (b) If veteran, name war: World

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Gertrude T. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1897

8. AGE: Years	Months	Days	If less than one day
47	8	22	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Electrical Business

FATHER

12. Name Turner A. Miller

13. Birthplace Va.

MOTHER

14. Maiden Name Annie Lala Savey

15. Birthplace Va.

16 (a) Informant Mrs. Catherine M. Pollard

(b) Address 26 Kempshall Place, Elizabeth N. J.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)

(c) Cemetery or crematory Hollywood Cem.

Location Richmond, Va.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) AUG 4 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1945 to 8/3 1945, and that I last saw h[illegible] alive on 8/3 1945.

Immediate cause of death	Duration
Respiratory & Cardiac Failure	
Due to Cerebrosis of Liver	
Due to	
Other Conditions Delerium Tremens. Delirium Tremens	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(c) Means of injury

23. Signature [illegible] Address St. Agnes Hosp. Date signed 8/3/45

VS 150

G31294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Jefferson St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William High
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day: hr.	min.
37				

9. Birthplace Richmond Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Amply Jones
(b) Address 1520 Jefferson St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvs Cem Balt
Location
18 (a) Funeral director Ethan O Wilson
(b) Address 1000 Brantley
(Signature of Funeral Director) Huntington Williams, M.D.

AUG 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1945 at 9:00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1945 to 7/31 1945, and that I last saw him alive on 7/31 1945.

Immediate cause of death Communicating hydrocephalus — Duration 3 days or more
Due to Chronic basilar leptomeningitis and
Due to Spinal arachnoiditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Communicating hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J M Parham M. D.
Address University Hospital Baltimore, Md Date signed 8/1/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

G31295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13 B

Registered No. G31295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Balto City Hospital 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Central Ave (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William Cheatham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	married

6 (b) Name of husband or wife Helen Cheatham
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			..... hr. ..... min.

9. Birthplace Richmond Co. Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Bazell Cheatham
13. Birthplace Va

MOTHER
14. Maiden Name Josephine Neal
15. Birthplace Va

16 (a) Informant Helen Cheatham
(b) Address Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)
(c) Cemetery or crematory.....
Location Richmond Co. Va

18 (a) Funeral director Elson O. W. Wilson
(b) Address 1000 Brantleyane

19 (a) AUG 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945, at 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature B. P. Lubinski M.D. Medical Examiner.
Date signed 8/4/45

G31296

474039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31296 / 1574

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Bristol
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Wagners Alley.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Winfred R. Niaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-38

8. AGE: Years	Months	Days	If less than one day
7.	-	7	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred. Niaffer
13. Birthplace Penn.

MOTHER
14. Maiden Name Elizabeth Howe
15. Birthplace Penn.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 4 46 (month) (day) (year)
(c) Cemetery or crematory Gunning Cem.
Location Bristol Va.

18 (a) Funeral director Mahaffee & Dingeldein
(b) Address 378 Penn St.

AUG 4 - 1945 Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May. 15 1945 to Aug. 3 1945, and that I last saw him alive on Aug. 3 1945.

	Duration
Immediate cause of death: Electrolyte imbalance	3 days
Due to: Stasis in bowel	
Due to: Uretero-intestinal transplant	22 days
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 6/25/45 7/12/45

Major findings of operation: Uretero-intestinal transplant

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lemuel H. Henry M.D.
Address Date signed 8/3/45

Dr. Butler
101 N Francis Ave.
G31297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 557

G31297 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3217 Leeds Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Leeds Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME George L. Dill

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-12-7559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Justina Dill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 26, 1880

8. AGE: Years	Months	Days	If less than one day: hr.	min.
64	10	8		

9. Birthplace Catonsville, Balto County, Md (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business Self

FATHER
12. Name Frederick Dill
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Heidlebach
15. Birthplace Maryland

16 (a) Informant Mrs. Laura Bowie
(b) Address 3217 Leeds Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-45 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

AUG 5 - 1945 (Date received by Registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1945, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944, to Aug 3 1945, and that I last saw h[illegible] alive on Aug 2 1945.

Immediate cause of death

Due to Carcinoma of antrum

Due to c[illegible] to [illegible]

Other Conditions Pelvic fracture
DEHYdration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
1 Yrs
48 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederic V. Butler M. D.
Address Medical Arts Bldg - Balto 1 Date signed 8-4-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G31298

Direct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6105 Park Heights Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6105 Park Hgts. Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Steinhorn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	White	Married

6 (b) Name of husband ~~or wife~~ Hyman Steinhorn
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 15, 1974

8. AGE: Years	Months	Days	If less than one day
61	2	19	hr. min.

9. Birthplace ~~Country~~ Sniatin, Galicia
(Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Abraham Gouldner
13. Birthplace Galicia

MOTHER
14. Maiden Name Mollie Schoener
15. Birthplace Sniatin, Galicia

16 (a) Informant Hyman Steinhorn
(b) Address 6105 Park Hgts. Av.

17 (a) Burial (b) Date thereof Aug. 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis
(b) Address 2400 Eutaw Place.

19 (a) Date received 1945 (b) Registrar Huntington Willi[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8. 3 1945 at 6 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1929, to 8.3 1945, and that I last saw her alive on 8. 1. 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Cardio-Vascular Disease	
~~Due to~~	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. S. Rubinstein
Address 2349 Eutaw Pl. Date signed 8/3/45

VS 150

G31299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 MO

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE. (If outside city or town limits, write RURAL and give town)
(d) Street No. FLORENCE CRITTENDEN HOME (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No) If yes, name country

3 (a) FULL NAME ANTHONY JUNIOR GROSSO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1946

8. AGE: Years	Months	Days	If less than one day
	3	17	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unkn. 13. Birthplace

MOTHER 14. Maiden Name Unkn. 15. Birthplace

Dept. Public Welfare Child

16 (a) Informant SUPT. - CRITTENDEN HOME
(b) Address 36th & Chestnut - City -

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 7225 Eastern Ave -

18 (a) Funeral director John J. Conway & Son
(b) Address 901-03 Wallace St -

19 (a) 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1945, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1945 to 8-4 1945, and that I last saw h. alive on 8-4 1945.

Immediate cause of death CARDIAC FAILURE — Duration

Due to CEREBRAL EDEMA

Due to DEHYDRATION HYPERPYREXIA

Other Conditions Acute Nutritional DIARRHEA

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mordekiyah Spraguin M. D.
Address U. M. H. Date signed 8-4-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

161 C

M. D. B. 1208-6

G31300 ✓ G31300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

927

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 W Fayette St. W Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Bessie Robinson

(a) Residence: No. 1039 W. Fayette St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Mar

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Aug 23, 1904

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Elijah Wickerson

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Mary Slinder

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Edward Robinson

(Address) 5236 Belmore Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Olivet Date 8-5 19[illegible]

19. UNDERTAKER Mrs. Katie R. Willing

(Address) 322 N Schroeder St. Waverly, Md.

20. AUG 6 - 1945 19 Huntington for Williams, Md.
Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 1, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 17, 1945 to August 1, 1945

I last saw her alive on August 1, 1945. Death is said to have occurred on the date stated above, at 8 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chr. Valvular Heart Disease	1 yr.

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Wilmonald Bando M. D.

(Address) 2445 Druid Hill Ave.

G31301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13-7a

G31301
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 W. Green St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John 2. Knode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1867

8. AGE: Years	Months	Days	If less than one day
78	3	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Elias Knode
13. Birthplace Wash. Co. Md.

MOTHER
14. Maiden Name Trotzman
15. Birthplace Hagerstown Md

16 (a) Informant Margaret Knode
(b) Address 49 W. Green St. Westminster, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/45 (month) (day) (year)

(c) Cemetery or crematory Westminster Cem.
Location Westminster Md.

18 (a) Funeral director J. S. Myers Jr.
(b) Address Westminster Md.

19 (a) AUG 6 — 1945 (Registered by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1945 to August 5 1945 and that I last saw him alive on Aug 5 1945

Immediate cause of death Uremia & Cystitis — Duration 7 days

Due to ~~Cancer~~ postoperative collapse

Due to Transurethral resection for benign prostatic hypertrophy & hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7-30-45
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caudell M. D.
Address Md. Gen. Hosp. Date signed 8-5-45

VS 150

G31302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31302

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Woodbine (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clay Brightwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Charlie Brightwell
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Bloom
15. Birthplace Maryland

16 (a) Informant Jesse Brightwell
(b) Address Woodbine. Md.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Poplar Springs
Location Howard Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Sykesville

19 (a) AUG 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1945 at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1945 to 8/5 1945 and that I last saw h. alive on 8/5 1945

Immediate cause of death Respiratory & Circulatory Collapse — Duration 3 weeks

Due to Heart failure

Due to Possible Cerebral hemmorhage or Coronary Thrombosis

Other Conditions Ca Pulmonis, Bronchitis, Bronchiectasis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilson Robinson M.D.
Address University Hospital Date signed 8/5/45

VS 150

X

G31303-51
A 42

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Forest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Harris

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S.

6 (b) Name of husband or wife
6 (c) If alive, give age 6-27-45 years

7. Birth date of deceased (mo., day, yr.) 8-27-44

8. AGE: Years	Months	Days	If less than one day
1	1	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carroll Harris
13. Birthplace Maryland

MOTHER
14. Maiden Name Colleen Loffe
15. Birthplace North Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/6/45
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar) AUG 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2 1945, at 11 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-45 1945 to 8-2 1945, and that I last saw h[illegible] alive on 8-2 1945

Immediate cause of death	Duration
Terminal Septicaemia	
Due to Mastoiditis - (Bilateral)	
Due to Otitis Media (Bilateral)	
Other Conditions Diarrhea	

(Include pregnancy within 3 months of death)
Date of operation 8-2-45
Major findings of operation: Purulent material in both Mastoids.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8-2-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31304 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cator

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months 45 | Days | If less than one day hr. min.

9. Birthplace Birmingham Ala.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Hanna Butler
(b) Address 204 - Myrtle ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 7 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 - Lord Baltimore

19 (Filed by registrar) AUG 6 - 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH July 27, 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 27 1945

G31305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

G31305

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur E. Roden

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Leona Roden
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1884

8. AGE: Years	Months	Days	If less than one day
61	5	29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Assistant Chief Clerk
11. Industry or business B. & O. R.R.

FATHER
12. Name Bernard Roden
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Revell
15. Birthplace Ireland

16 (a) Informant Mrs. Leona Roden
(b) Address 1713 Wilkens Ave.

17 (a) Burial (b) Date thereof 8-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 702 W. Lombard St.

19 (a) AUG 6 - 1945 Hunterator Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-45 19 , at 6:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2-45 19 , to 8-2-45 19 , and that I last saw him alive on 8-2-45. 19

Immediate cause of death Hyperzephroma Left Kidney. Secondary Liver.

Duration
3a mon yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. V. Rangle
Address 642 Wash. Blvd Date signed 8-7-45

VS 180

(To be approved by Medical Examiner.) H. J. Mallis M.D.

G31306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G31306 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Light St
(c) Hospital or institution: Lovely Bros. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1746 S. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA C. SCOTT (Annie Catherine Scott)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William J. Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18 1877

8. AGE: Years 68 | Months 5 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name Frederick Wellman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Angeline Hiss
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William F. Willman
(b) Address 1746 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 7th 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore County, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) ..... (b) .....
(Date received by Registrar) Registrar

AUG 6 1945 Huntington Willman, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1945, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to Aug 4 1945 and that I last saw her alive on Aug 4, 1945.

Immediate cause of death: Carcinoma of Large Bowel — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Madison Blanton M. D.

Address Lovely Bros Gen Hosp Date signed Aug 4, 1945

X

G31307 ✓ G31307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 15 10

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3807 Belle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALOYSIUS JOSEPH EFF

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nettie D'Angelo Eff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1897

8. AGE: Years	Months	Days	If less than one day
47	7	18	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Contractor
11. Industry or business

FATHER
12. Name Otto Eff
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Walhauser
15. Birthplace Germany

16 (a) Informant Mrs. Nettie D. Eff
(b) Address 3807 Belle Ave.

17 (a) Burial (b) Date thereof 8/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) AUG 6 1945 Huntington Williams, M.D.
(Date city registrar received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1945, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945, to Aug 3 1945, and that I last saw him alive on Aug 3rd 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension & nephritis	3 years
Due to	
Other Conditions Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Poulton M. D.
Address 3904 Gunnon Blvd Date signed

VS 150

G31308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G31308 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address n Calhoun St 24
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1259 Riverside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fritz-Susan Ann

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	W	Widow

6 (b) Name of husband or wife Alexander C. Coy Fritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	3	hr. min.

9. Birthplace Essex Co. Va (Town, county, and state)
10. Usual Occupation H W
11. Industry or business

FATHER
12. Name Henry Coy
13. Birthplace Essex Co Va

MOTHER
14. Maiden Name Martha Clark
15. Birthplace Essex Co. Va

16 (a) Informant Franklin Square Hosp
(b) Address n Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. Tejener & Son
(b) Address Balto, Md.

AUG 6

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1945, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1945, to Aug 3 1945, and that I last saw h ext alive on Aug 3 1945.

Immediate cause of death generalized Cachexia — Duration

Due to generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Cauce M. D.
Address Franklin Square Hosp. Date signed 8/3/45

VS 150

146758 G31309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31309 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1578 Charlotte Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Charlotte

3 (a) FULL NAME Conrad Bentrup

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-20-'70

8. AGE: Years	Months	Days	If less than one day
75	4	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Penna R.R.

FATHER
12. Name Jos Bentrup
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Krauss
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Lilly & Zile, de
(b) Address 403 S. Wolfe Street

19 (a) (Date rec'd by registrar) (b) Registrar

vs AUG 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1945 at 2 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19, 1945 to Aug. 2, 1945 and that I last saw him alive on Aug. 2, 1945

Immediate cause of death Cholemia

Due to Cancer Carcinosis of liver — Cancer

Due to

Other Conditions Arteriosclerosis diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graham G. Vance

Address Johns Hopkins Hospital Date signed 8/2/45

124a

TAUBMAN

G31310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G31310 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ambulance
(c) Hospital or institution: St. Joseph's 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Bell St. (If rural give location)
(e) Citizen of foreign country? Austria NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Joseph F. Taubman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/79

8. AGE: Years	Months	Days	If less than one day
65	8	21	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Employee
11. Industry or business B.T.C.

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant family. 1704 Bell St.
(b) Address

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-6-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Bright Gr. J. D. Handly

18 (a) Funeral director
(b) Address 130 S. Fremont Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1945, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10/45 19..., to 8/3/45 19..., and that I last saw him alive on 8/3/45 19...

Immediate cause of death Pulmonary embolism & pneumonia

Due to

Due to

Other Conditions Carcinoma of Stomach c metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Rodgers M. D.
Address St. Joseph's Hospital Date signed 8/3/45

X

G31311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G31311

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1448 William St.
(c) Hospital or institution:
24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1448 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Mahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	18	hr. min.

9. Birthplace Delaware.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thos. H. Mahan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary F. Lutz
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1448 William St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8-6-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director James L. McCauley
(b) Address 520 S. Fort Ave.

19 (a) Registered by Registrar AUG 6 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1945 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945 to Aug 3 1945, and that I last saw h-m alive on Aug 1 1945.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Arterio sclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 6 Market St. Date signed 8/5/45

G31312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. G31312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcella T. Regan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27th 1886

8. AGE: Years: 58 | Months: 11 | Days: 17 | If less than one day: hr. min.

m. 13.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Mette Bros.

FATHER
12. Name Thomas J. Regan
13. Birthplace Ireland

MOTHER
14. Maiden Name Marcella Beehan
15. Birthplace Balto Md.

16 (a) Informant Thomas J. Regan
(b) Address 1305 Lakeside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

AUG 6 - 1945 (Date rec'd by registrar) (b) Huntington Millimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945, at 9 20 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Septicemia, Necrotic Pelvic Abscess

Due to Rectal Fistula

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed August 4 1945

G31313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

Registered No. G31313

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 11
(e) Length of stay in Baltimore (yrs., mos., or days) 29

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles ab. 40 (If rural give location)
(e) Citizen of foreign country? Yes or ~~No~~ If yes, name country

3 (a) FULL NAME Sister E. Regis (Garrity)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18-1890

8. AGE: Years	Months	Days	If less than one day
55	5	17	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Superior
11. Industry or business Notre Dame Convent

FATHER
12. Name Nicholas Garrity
13. Birthplace Ireland

MOTHER
14. Maiden Name Cath. Martin
15. Birthplace Ireland.

16 (a) Informant Sr. M. Francis.
(b) Address Notre Dame Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Grounds
18 (a) Funeral director Geo M. Smith & Son
(b) Address 811 N Howard St
19 AUG 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5/1945 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19/1945 to 8/5/1945 and that I last saw her alive on 8/5/1945

Immediate cause of death: Metastatic Carcinoma (Involving Vertebrae) — Duration: 2 Mo.
Due to: C.A. Uterus & Cervix
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: C.A. Uterus & Cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Norton, Jr. M.D.
Address Bon Secours Hosp Date signed 8/5/45

VS 150

G31314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

+93D ✓ Registered No. G31314

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospitol
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Shareland (If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. Lot 173 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Cooper

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
?	?	M	W	M

6 (b) Name of husband or wife Mildred Cooper
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) July 31, 1883

8. AGE: Years	Months	Days	If less than one day
62	X	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Tavern Owner
11. Industry or business

FATHER
12. Name Robert Cooper
13. Birthplace Md

MOTHER
14. Maiden Name Anna Boblitz
15. Birthplace Md.

16 (a) Informant Mildred Cooper
(b) Address 6 N. Stricker St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-8-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Frank Bruchhaus
(b) Address 900 N. Charles St

19 AUG 6 - 1945 (b) Registered by Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1945, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1945, to Aug 4 1945, and that I last saw him alive on Aug 4 1945.

	Duration
Immediate cause of death Cardiac Failure	24 hrs.
Due to Hypertensive Arterio-sclerotic C-V. disease	?
Due to	
Other Conditions Hepatitis?	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent de P. Fitzpatrick Jr. M.D.
Address Mercy Hospital Date signed 8/4/45

X

G31315 ✓ G31315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: V.A. Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 E. Balto (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ambrose Fritsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22. 1880

8. AGE: Years	Months	Days	If less than one day
64	9	12	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Aloysious Fritsch

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Benning

15. Birthplace Germany

16 (a) Informant George J. Fritsch

(b) Address 2616 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4300 Belair Rd

18 (a) Funeral director Martin F. Kopp

(b) Address 37 S Conkling

19 (a) (Officer or registrar) (b) Registrar

AUG 6 1945

Washington, D.C.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/45 19 at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 19 44 to 8/4 19 45.
and that I last saw h alive on 19 .

Immediate cause of death 1 Cardiac failure

Due to

Due to

Other Conditions Psychosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Matthew J. Jaworski M. D.

Address V.A. Hospital Date signed 8/6/45

M. JAWORSKI

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31316 BAADER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G31316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d 4
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Caherton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Baader

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1866

8. AGE: Years	Months	Days	If less than one day
79	3	11 10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Meier
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Henry Baader
(b) Address 2152 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-45 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road Balto
18 (a) Funeral director Geo. L. Schwab Co.
(b) Address 2101 Frederick Ave. Baltimore, Md.

AUG 6 - 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945, at 9:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing Injuries to body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 8-4-45
(a) Date of injury August 4 1945 9 45 M.
(b) Where did injury occur? Pagan St & Riggs Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by train

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed August 4 1945

VS 151

X

G31317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15

Registered No. G31317

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 McDonough St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 McDonough St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leola Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Benjamin Stokes
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 3-5-1898

8. AGE: Years	Months	Days	If less than one day
47	4	29	hr. min.

9. Birthplace Crew Va (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Robinson
13. Birthplace Va

MOTHER
14. Maiden Name unk.
15. Birthplace

16 (a) Informant Mrs. Blanche Jeffries
(b) Address 202-A Stevenson Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Md

18 (a) Funeral director Charley K. Law
(b) Address 802 Mad. Ave.

19 (a) (Date received by registrar) (b)

AUG 6 1945 Huntington Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1945 at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/21 1945 to 8/4 1945 and that I last saw h e r alive on 8/2 1945

Immediate cause of death	Duration
Tubercular peritonitis	unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1320 E. McDonough St Date signed 8/6

[illegible] Browne X

G31318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G31318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 N. Bradford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marguerite E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1903

8. AGE: Years	Months	Days	If less than one day
42		25	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Helper on Beer Truck
11. Industry or business Gunther Brewing Co.
FATHER 12. Name George Thomas
13. Birthplace Bavaria
MOTHER 14. Maiden Name Anna Luchanek
15. Birthplace Balto Md.
16 (a) Informant Marguerite E. Thomas
(b) Address 1201 N. Bradford St
17 (a) Burial (b) Date thereof Aug 7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md.
18 (a) Funeral director John C. Miller Inc
(b) Address 2495 E. Oliver St
19 (a) (b) Huntington Williams
(Date received by registrar) Registrar
AUG 6 1945
VS 15f

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 45, 19, at 7:50 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Traumatic rupture of Aorta

Due to Fractured Ribs.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury P. M. at 8-3-45 10/1
(b) Where did injury occur 920 in front of E. Biddle St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.
(d) Means of injury Beer keg struck him on chest.

23. Signature Thomas J. Mueller M.D.
Medical Examiner.
Date signed August 4, 1945.

M. D. R. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G31319 47D G31319

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mount St Stadium Ward) 19

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Sister Mary of the Blessed Sacrament (Elizabeth Riley)

(a) Residence: No. Convent of the Good Shepherd Mt St Hellgate. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day, year) May 31, 1900

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	2	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Invalid

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME Elizabeth Riley

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md

MOTHER

15. MAIDEN NAME Caroline Wagner

16. BIRTHPLACE (city or town) (State or country) Baltimore Md

17. INFORMANT Sister M of the Holy Child (Address) 15 E. Mount Street

18. BURIAL, CREMATION, OR REMOVAL Place Baltimore Date 8/7/ 1945

19. UNDERTAKER J. J. Tabory Sons (Address) 218 Light.

20. FILED AUG 6 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 5 1945

22. I HEREBY CERTIFY, That I attended deceased from Apr 1945 to Aug 5 1945

I last saw her alive on Aug 3 1945 Death is said to have occurred on the date stated above, at 11 40 AM

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma Lung	2/3
Other contributory causes of importance:	

Name of operation — Date of —

What test confirmed diagnosis? X Ray Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) Geo A Krauss M. D.

(Address) 1500 N Charles St

OCCUPATION is very important. See instructions on back of certificate.

G31320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31320 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Trentler

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-2378

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Regina D. Trentler
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6/24/1861

8. AGE: Years	Months	Days	If less than one day
84	1	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home Maker
11. Industry or business None Sanitary Mfg Co

FATHER
12. Name Joseph Trentler
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant Mrs Regina D. Trentler
(b) Address 2203 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md

18 (a) Funeral director F. B. Wisbert & Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) AUG 6 - 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2nd 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Aug 2 1945 and that I last saw him alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	July 1945
Due to Chr. Myocarditis	July 1944
Due to Arteriosclerosis	1935
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William [illegible] M. D.
Address 1 E. Lexington St Date signed Aug 3 1945

G31321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G31321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 125 H. (Balto. City Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 E. Faye Ave 51
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Powell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1894

8. AGE: Years	Months	Days	If less than one day
51		23	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Powell
13. Birthplace Md

MOTHER
14. Maiden Name Mary
15. Birthplace Md

16 (a) Informant John Watkins
(b) Address 146 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7th 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Dr. Av. Co. Md

18 (a) Funeral director Belmont Francis H. Kruger
(b) Address 721 Pennsylvania Ave Huntingtown Williamsport Md

19 AUG 6 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Ruth B. Cockaday M.D. - Medical Examiner.
Date signed 8/4/45

VS 151

G31322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G31322 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County anne Arundel
(c) City or town Linthicum Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Hammonds Ferry Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Juergen F. Peters

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: annie M. Peters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26th 1856

8. AGE: Years 89 | Months 4 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Juergen F. Peters
13. Birthplace Germany

MOTHER
14. Maiden Name Katrina Martin
15. Birthplace Germany

16 (a) Informant Mr. Charles H. Peters (SON)
(b) Address 208 S. Hammonds Ferry Rd. Linthicum Heights, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 7th 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) AUG 6 1945 Huntington Williams, M.D.
(b) Date received by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4-45 19... at 6:42 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1945, to 8-4 1945, and that I last saw him alive on 8/4 1945.

Immediate cause of death	Duration
Peripheral vascular collapse	
Due to Debilitation	
Due to	
Other Conditions Fracture - neck of right femur (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 21, 1945
(c) Where did injury occur? 208 S. Hammonds Ferry (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) At home While at work? No
(e) Means of injury Slipped & fell to floor

23. Signature Howard J. Mendenhall M.D.
Address Maryland General Hospital
Date signed 8/4/45

VS 150

For Dr. J. R. Davis - Howard J. Mendenhall M.D.

G31323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31323

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Berryman's Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Sylvester Bollinger

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Margaret C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/20/1871

8. AGE: Years 74 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Manchester, Md. (Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name Emmanuel Bollinger
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Wareheim
15. Birthplace Carroll Co. Md.

16 (a) Informant Mr. Michael J. Bollinger
(b) Address 2765 Alameda Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. 17

19 AUG 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/ 19 45 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4/ 19 45 to 8/4/ 19 45
and that I last saw h[illegible] alive on 8/4/45 19 45

Immediate cause of death: Coronary Occlusion — Duration

Due to: Arteriosclerosis

Due to

Other Conditions: Pulmonary Edema

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Tortorich Jr. M.D.
Address Bon Secours Hosp Date signed 8/6/45

VS 150

G31324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31324

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Oakfield Avenue
(c) Hospital or institution:
15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Oakfield Avenue. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith C. Minnick

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Millard F. Minnick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 15 1866

8. AGE: Years	Months	Days	If less than one day
78	10	19	hr. min.

9. Birthplace Howard County, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Joseph Maclin
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Pindell
15. Birthplace Maryland.

16 (a) Informant Mrs. Alice Jones
(b) Address 3300 Oakfield Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 7th 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 AUG 6 - 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 5th 1945, to Aug. - 4 1945 and that I last saw h[illegible] alive on Aug. - 4 1945

Immediate cause of death 1) - Hypertensive Heart Disease — Duration 5 yrs.
Due to
Due to
Other Conditions - Chronic Glomerular Nephritis — Duration - 1 yr.
(Include pregnancy within 3 months of death)
Date of operation - None
Major findings of operation: -
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature - Earl L. Chambers M. D.
Address 4108 - Liberty Hts. Date signed 8/6/45

93D

VS 150

G31325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1004 N. Arlington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Arlington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Corbin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Queen Corbin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1895

8. AGE: Years	Months	Days	If less than one day
50		14	hr. min.

9. Birthplace (City, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Corbin
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Jones
15. Birthplace Va.

16 (a) Informant Queen Corbin
(b) Address 1004 N. Arlington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-45 (month) (day) (year)
(c) Cemetery or crematory Bals National
Location Baltimore, Md.

18 (a) Funeral director Jas. H. Chase Son
(b) Address 638 N. Eutaw

19 (a) Filed AUG 6 1945 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 19 45, at 9:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 19 45, to Aug 3 19 45, and that I last saw him alive on May 15 19 45

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Cardio Vascular Disease.	1 yr.
Due to Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Wallace Free M. D.
Address 921 Penna. Ave. Date signed 8/7/45

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G31326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V170C

G31326 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General (Dorsey)
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Arsan (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Michaels, Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months 40 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name George Michael
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Florence Justice
15. Birthplace Baltimore Md

16 (a) Informant Mrs Florence Michael
(b) Address 2931 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8. 7 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 201 E. 22nd St

19 Filed 8-6-1945 (b) Huntington Williams, M.D. Registrar
Recorded by 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1945 at 2 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Crushed Chest

Due to

Other Conditions Other fractures, lacerations, contusions + bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-4-45 at 23.3 (1 30) A M.
(b) Where did injury occur? Hanover St 175' north of Cromwell St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto into pole

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 8-4-45

X

G31327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9513

G31327

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 E. Eager Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 E. Eager Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL JOSEPH MASKELL

3 (b) If veteran, name war: World War # 1

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Maskell

6 (c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1891

8. AGE: Years: 53 | Months: 7 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Foreman, Water Dep't.

11. Industry or business: City of Baltimore

FATHER
12. Name: Thomas Maskell
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Anna Hopper
15. Birthplace: Baltimore County

16 (a) Informant: Mrs. Mary Maskell
(b) Address: 1621 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b)
Date recd by registrar: AUG 6 - 1945 Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3 1945 at 5.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to Aug 3 1945 and that I last saw him alive on Aug 2 1945

Immediate cause of death: Cardiac failure

Due to: Rheumatic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: O. Shoroboly MD

Address: 600 N. Monroe Date signed 8/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31328 G31328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE CECELIA GONNSEN

3 (b) If veteran, name war NO

3 (c) Social Security Account No. none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Paul C. Gonnsen
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1857

8. AGE: Years 88 | Months 6 7 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Pruess
13. Birthplace Germany

MOTHER 14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Anita Linder
(b) Address 2116 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9. 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) DEC 6 - 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 4, 1945 at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1945 to Aug 4 1945, and that I last saw h alive on Aug 3 1945.

Immediate cause of death	Duration
Enterocolonitis Hemorrhagica	
Diarrhea	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1213 E. North Ave Date signed 8/5/46 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G31329 G31329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Kingsway Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOHN J.V. MEISENHALDER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	216-01-1957	Male	White	Married

6 (b) Name of husband or wife Catherine Maisenhelder
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1905

8. AGE: Years	Months	Days	If less than one day
40	6	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business American Brewery

FATHER
12. Name John V. Meisenholder
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Amelia Mittag
15. Birthplace Germany

16 (a) Informant Mrs. Catherine Meisenhalder
(b) Address 1504 Kingsway Road

17 (a) Burial (b) Date thereof 8/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 AUG 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to Aug 5 1945, and that I last saw him alive on Aug 5 1945

Cause	Duration
Immediate cause of death Circulatory collapse	
Due to Myocardial weakness	
Due to Uremia AURICULAR	
Other Conditions Tuberculosis, emphysema nephritis, auricular fibrillation (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Lemon
Address University Hosp. Date signed 8/5/45 M. D.

X

G31330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31330 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Bayard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Bayard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary O. Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife: Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 5/13/1883

8. AGE: Years	Months	Days	If less than one day
62	2	18	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: Steve Chambers
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Rachael
15. Birthplace: Balto. Md.

16 (a) Informant: Wm. Smith (Son)
(b) Address: 1151 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location: Baltimore, County

18 (a) Funeral director: Charles Cooper
(b) Address: 512 N. Carrollton Ave.

19 (a) Filed [illegible] 1945 (b) Huntington Williamson, Md.

AUG 6 1945

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: Aug. 2nd 1945, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1945 to 8/2 1945, and that I last saw h[illegible] alive on 8/1 1945.

Immediate cause of death	Duration
Hypertension Cardiovascular Renal Disease	1 yr
Due to Hemiplegia	1
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W. L. Jackson M.D.
Address: 600 N. Carrollton Ave. Signed 8/6/45

X

G31331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G31331 Registered No.

1. **PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1813 Wilkens
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Worcester
(c) City or town Pocomoke
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Upshur J Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Susan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1872

8. AGE: Years 73 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Somerset Co Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name John Richardson
13. Birthplace Md

MOTHER
14. Maiden Name Emily Matthews
15. Birthplace Md

16 (a) Informant Mrs Elizabeth Emmett
(b) Address 1813 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 45 (month) (day) (year)
(c) Cemetery or crematory Bethany M Cem
Location Pocomoke Md

18 (a) Funeral director Dennis & Watson
(b) Address Pocomoke Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 6 - 1945

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Aug 5 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1944 to Aug 5 1945 and that I last saw h alive on Aug 5 1945

Immediate cause of death Edema of Lungs — Duration 24 hrs.

Due to

Due to

Other Conditions Chr. Nephritis — Chr. Myocarditis — 1 yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Lichtenberg

Address 708 E North Ave Date signed 8/5/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-95167 G31332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31332 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside St.
(If rural give location)
(e) Citizen of foreign country? * (Yes or No)
If yes, name country * * *

3 (a) FULL NAME Frank Pieger

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	NONE	M	W	Single

6 (b) Name of husband or wife *
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) May 16- 1872

8. AGE: Years	Months	Days	If less than one day
73	2	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business

FATHER
12. Name John Pieger
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Wernerdoefer
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof AUG 7- 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt Royal Ave

19 (a) [illegible] (b) Huntington Williams M.D. Registrar

AUG 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1945, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945, to 8-3 1945 and that I last saw him alive on 8-3- 1945

Immediate cause of death	Duration
cardiac and respiratory failure, with uremia	
Due to coronary arteriosclerosis.	
Due to arteriolosclerosis	
Other Conditions Pulmonary oedema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: coronary arteriosclerosis
of autopsy: arteriolosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Woodward M. D.
Address B-C-H. Date signed 8/4/45

X

G31333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31333 Registered No. 12B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4328 Roland Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 Roland Court
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE JOSEPH GOLDSBOROUGH

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 216-05-1202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Juliet Goldsborough
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1891

8. AGE: Years	Months	Days	If less than one day
54	4	20	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Records-Goldsborough

FATHER
12. Name Henry P. Goldsborough
13. Birthplace Maryland

MOTHER
14. Maiden Name Helena McManus
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Juliet Goldsborough
(b) Address 4328 Roland Court

17 (a) Burial (b) Date thereof 8/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address Mt. Royal Ave. Baltimore, Md.

19 (a) AUG 6 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 19 45 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 42, to Aug 4 1945 and that I last saw h alive on Aug 4 1945.

Immediate cause of death: Tuberculosis Pulmonary Anemia ?
Duration: Unknown Unknown

Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. R. Goldsborough M. D.
Address 2923 St Paul St Date signed 8/5/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G31334 Registered No.

JO 94842

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Popowski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1870

8. AGE: Years	Months	Days	If less than one day
75	-1-	19	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sam Popowski
13. Birthplace Poland

MOTHER
14. Maiden Name Maria Ziacawski
15. Birthplace Poland

16 (a) Informant Records, Balto. City Hospital
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Furman Hall Rd.

18 (a) Funeral director James Buczkowski
(b) Address 1467 Eastern Ave. Dundalk Rd.

19 (a) (Registrar's signature) (b) Registrar
AUG 6 1945
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1945, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19, 1945, to Aug. 3, 1945, and that I last saw him alive on Aug. 3, 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Increased intra-abdominal pressure.	2 days
Due to CARCINOMA OF Prostate with abdominal metastasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operations:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto. City Hospitals Date signed 8-3-45
X

1335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 6 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

2589

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed July 20 1945

a 42 G31336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G31336

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County St. Mary's
(c) City or town Hermanville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Joan Elizabeth Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-45

8. AGE: Years	Months	Days	If less than one day
	3	21	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Lewis
13. Birthplace Virginia

MOTHER
14. Maiden Name Alnedra Willis
15. Birthplace Virginia

16 (a) Informant Nurses
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location [redacted]

18 (a) Funeral director Leonard M. Shaw Funeral Home
(b) Address 638 N. Gilmor St.

19 (a) AUG 6 1945 (Date received by Registrar) (b) Registrar
Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945 at 8 45/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945 to 8-6 1945 and that I last saw her alive on 8-6 1945

Immediate cause of death: Acute gastro-enteritis and dehydration
Due to Diarrhea
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gordon Jr. M. D.
Address JHH Date signed 8/6/45

X

Please write in ink, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31337 Registered No. 1172

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 S. Macon
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Macon St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Katie Ahalen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widowed

6 (b) Name of husband or wife James J. Ahalen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4-1885

8. AGE: Years	Months	Days	If less than one day
60	1	0	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen
15. Birthplace Ireland

16 (a) Informant Mrs. Nellie Shanblin
(b) Address 302 S. Macon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John F. Connelly
(b) Address 418 Gaston Ave. Huntington Williams, Mgr.

19 (a) (Date received by registrar) (b) Registrar

AUG 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4th 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945, to Aug 4 1945, and that I last saw her alive on Aug 3 10 1945.

Immediate cause of death Starvation Cachexia from Ulcers of Mouth — Duration 6 mos.

Due to Septic Ulcerative Pulpitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Dwight D. Geller, M.D.
Address 3336 Balto St. Date signed 8/6/45

G31338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G31338 Registered No.

JO #95102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 541
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 884 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Harold C. Duke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1945

8. AGE: Years	Months	Days	If less than one day
----	1m	18	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Grover Duke
13. Birthplace: Kentucky

MOTHER
14. Maiden Name: Beatrice Hatfield
15. Birthplace: Tennessee

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (date) (year) 8/7/45

(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore Md.

18 (a) Funeral director: Wilson & Lee
(b) Address: 1217 E. Baltimore St.

19 (a) Date received: AUG 6 1945 (b) Registrar: Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1945, at 1:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30, 1945, to Aug. 5, 1945, and that I last saw him alive on Aug. 4, 1945.

Immediate cause of death	Duration
Congenital Syphilis	6 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital Lues

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John E. Lazenati, M.D.
Address: (Balt. City) Date signed: 8/6/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G31339

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Bruce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Hezekiah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1919

8. AGE: Years 25 | Months 11 | Days 21 | If less than one day: hr. min.

9. Birthplace East Spencer, N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Walker.
13. Birthplace Concord, N.C.

MOTHER
14. Maiden Name Mary Douglass
15. Birthplace Concord, N.C.

16 (a) Informant David Walker.
(b) Address 12 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 320 N Schroeder St

19 (a) (Date rec'd by registrar) Huntington Williams Registrar
AUG 6 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1945, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-2-45 at 1:00 A. M.
(b) Where did injury occur? 12 N. Bruce St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbing

23. Signature Rene A. Gutow M.D.
Medical Examiner.
Date signed August 2 - 1945

G31340 G31340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Hillman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 75-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Hillman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Bersterman Sr.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Josephine C. Kennedy Bersterman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 22, 1869
8. AGE: Years 75 Months 11 Days 14 If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county and state)
10. Usual Occupation: General Laborer
11. Industry or business:

FATHER
12. Name: George Bersterman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Rommell
15. Birthplace: Germany

16 (a) Informant: Mrs. Josephine C. Bersterman
(b) Address: 1001 Hillman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8, 1945 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: 4700 Belair Rd.

18 (a) Funeral director: Edmund W. Coyle Sr.
(b) Address: 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 7 1945 Washington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945 to Aug 5 1945 and that I last saw him alive on Aug 5 1945.

Immediate cause of death: Acute Coronary insufficiency — Duration

Due to: Chronic Sclerosis

Due to: Ch. Myocardial

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury: —

23. Signature A. H. Hornstein M.D.
Address 733 August Ave Date signed 8/16/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G31341

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3208 Barclay St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo

(e) Length of stay in Baltimore (yrs., mos., or days) 8 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3208 Barclay St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Smith Gilbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	Col	Married

6 (b) Name of husband or wife Corelous

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1877

8. AGE: Years	Months	Days	If less than one day
68	6	27	hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER

12. Name Louis Gilbert

13. Birthplace ala

MOTHER

14. Maiden Name Priscilla ?

15. Birthplace ala.

16 (a) Informant Corelious Gilbert

(b) Address 3208 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 8 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A. A. County Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

AUG 7 - 1945 Huntington Williams, M.D.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 19 45 at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 45, to Aug 4 19 45, and that I last saw h— alive on Aug 4 19 45

Immediate cause of death Uremia Carcinoma of bladder

Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Louis D Jackson M.D.

Address 2329 Guilford Ave Date signed Aug 7 1945

VS 180

X

G31342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH J. HENSON

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1870

8. AGE: Years 75 | Months — | Days — | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name James H Henson
13. Birthplace Md

MOTHER 14. Maiden Name Mariah Hawkins
15. Birthplace Md

16 (a) Informant Sadie Henson Butler
(b) Address 1029 N. Central ave

17 (a) Burial (b) Date thereof 8-9-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. Co. Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave.

19 (a) AUG 7 - 1945 (b) Thurlington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5/45, 19, at 10:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Owen, M.D.
Medical Examiner.
Date signed 8/6/45

VS 151

G31343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31343 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline A. Wagner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1874

8. AGE: Years	Months	Days	If less than one day
71	1	15	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Eckhardt
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Edward Wagner
(b) Address 2808 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director D. J. Rusk
(b) Address 5305 Harford Rd

19 (a) AUG 7 1945 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1945 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Aug 4 1945 and that I last saw h[er] alive on Aug 1 1945

	Duration
Immediate cause of death: Bronchopneumonia	3 days
Due to: Hypertensive Cardio-vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Karl Grossman M. D.
Address 1212 N. Patterson Date signed 8/6/45

Huntington Hillcrest, W.Va.

Please X

G31344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31344

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2410 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, give RFD, and give town)
(d) Street No. 2410 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 - 1885

8. AGE: Years	Months	Days	If less than one day
60	5	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Wm J. Scott
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Mary J. Slayman
15. Birthplace Baltimore Md

16 (a) Informant Charles Scott
(b) Address 2410 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8-45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Homer's Lane

18 (a) Funeral director Jno. F. Valentine
(b) Address 2326 Aiken St.

19 (a) Filed AUG 7 1945 (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 19 to Aug 4 1945 and that I last saw him alive on Aug 4 1945.

Immediate cause of death	Duration
Acute cardiac failure	
Due to Ch myocardial weakness	
Due to Ch Hypertention	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Augusta St Date signed 8/5/45

X

G31345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31345

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1741 N. Bond St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary J. Fisher — Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frederick —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71	2	7		

9. Birthplace Bethel Conn. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Cornelius Diggins
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora Lenehing
15. Birthplace Ireland

16 (a) Informant Marie Lahuette
(b) Address 1741 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9. 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto Md

18 (a) Funeral director John A. Hyson
(b) Address 300 E. Balto. St.

19 (a) AUG 7 - 1945 (Date rec'd by registrar) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 — 1945 at 3 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 19 Aug 4 1945 and that I last saw h.: alive on Aug 4 19 45

Immediate cause of death	Duration
Acute Cerebral Hemorrhage	
Due to Ch Hypertension	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature A. L. Homstein, M.D.
Address 733 Augusta St Date signed 8/6/45

VS 150

G31346 3. G31346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 N. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna May Bering

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm. Jacob Bering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19-1873

8. AGE: Years	Months	Days	If less than one day
72	10	17	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home.

FATHER
12. Name William J. Knight
13. Birthplace Md

MOTHER
14. Maiden Name Rachel V. Hearish
15. Birthplace Md

16 (a) Informant Kenneth L. Bering
(b) Address 1902 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-45 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem.
Location Taylor Ave.

18 (a) Funeral director John C. Melly Inc
(b) Address 243 E. Oliver St

19 (a) (Date received by Registrar) (b) Hunting Town, Md.

AUG 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Aug 5 1945
and that I last saw h alive on Aug 5 1945.

Immediate cause of death
Carcinoma of Uterus
Due to Metastasis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 8/7/45

X

I HEREBY CERTIFY, that I attended deceased from July 1945 to Aug 5 1945, that I last saw h alive on Aug 5 1945, and that death occurred on the date above stated, at 3 A M, from the causes and at the times stated above. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure that age is especially important.

G31347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G31347

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2339 Eutaw Place.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 Eutaw Place. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME IDA K. MILLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Maurice L. Miller.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1880.

8. AGE: Years	Months	Days	If less than one day
64	9	7	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Heller,
13. Birthplace Germany.

MOTHER
14. Maiden Name Regina Kaufman,
15. Birthplace Germany.

16 (a) Informant Mrs. Louis Whitehill,
(b) Address 2339 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.8.45. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Edward Sonnenborn & Sons
(b) Address 1902 Eutaw Place.

AUG 7 - 1945 (a) (b) Harrington Williams Md.
(Date rec'd by registrar) registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6th. 1945 at AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to Aug. 6, 1945, and that I last saw h[illegible] alive on Aug. 5, 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isidor L. Levy
Address 2322 Eutaw Place. Date signed 8/6/45

X

NASH

HEALTH DEPARTMENT—CITY OF BALTIMORE

G31348

G31348

CERTIFICATE OF DEATH

50

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3516 Mt. Pleasant Ave St., 6 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mrs. Louisa Nash

If U. S. Veteran specify WAR .....

(a) Residence: No. 3516 Mt Pleasant Ave St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Dec 25th 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Md

FATHER

13. NAME —

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Mrs L Schmisch

(Address) 3516 Mt Pleasant Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Laudon Pk Date Aug 9th 1945

19. UNDERTAKER Leo F. Leo Cook

(Address) 1701-03 N Patterson Park Ave

20. FILED AUG 7 - 1945 19 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 6, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1945 to Aug 6, 1945

I last saw h[illegible] alive on Aug 4, 1945. Death is said to have occurred on the date stated above, at 6.45 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of breast	1943
recurrent 2 metastases	
Other contributory causes of importance:	

Was an operation performed? Yes Date of 1943 ± Ca of breast

For what disease or injury? Ca of breast

Name of operation Radical Mastectomy

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Theodore L. Grazzanti M.D.

(Address) 618 Medical Arts Bldg

OCCUPATION is very important. See instructions on back of certificate.

X

G31349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G31349

(over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Northway drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Northway drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Bruggemann

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Gerhardt Bruggemann
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan 17 - 1887

8. AGE: Years	Months	Days	If less than one day
68 58	6	18	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Michael Eberberger
13. Birthplace Germany

MOTHER
14. Maiden Name Lena LaLapp
15. Birthplace Germany

16 (a) Informant Mrs Dora Ulrich
(b) Address 9611 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

AUG 7 - 1945 (Date rec'd by registrar) (b) Huntington Williamson, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4th 1945 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to Aug 4 1945, and that I last saw her alive on Aug 4 1945.

Immediate cause of death	Duration
Carcinoma Stomach	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes (fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J S Hardesty M.D.
Address 4810 Belair Rd Date signed Aug 6/45

Please fill in all items, where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31350

G31350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1744 E Oliver
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1744 E Oliver St (if outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred C Blades

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Minnie Blades
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 - 1873

8. AGE: Years	Months	Days	If less than one day
72	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Retired

FATHER
12. Name Thomas Blades
13. Birthplace Md

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Mrs Alice Walters
(b) Address 1744 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Baltimore Md

18 (a) Funeral director Wellington Funeral Home
(b) Address 1008 Orleans

19 AUG 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7th 1945, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945 to 8/7 1945, and that I last saw h alive on 8/3 1945.

Immediate cause of death	Duration
Intercerebellar Hemorrhage	5
Disease	
Due to	
Due to	
Other Conditions C	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E Madison Date signed 8/6/45

VS 150

X

G31351

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G31351 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3/9 N Carrollton
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3/9 N Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ella Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1872

8. AGE: Years 72 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Ben Sewell
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Calvert Co. Md.

16 (a) Informant Sarah Sewell
(b) Address Calvert Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7, '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willing
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Washington Millender, Registrar

AUG 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 to Aug 2 1945.
and that I last saw h[illegible] alive on Aug 2 1945.

Immediate cause of death Arteriosclerosis — Duration 3 yrs

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Date signed Aug 8 1945 M. D.

G31352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G31352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernestine Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6, 1945

8. AGE: Years	Months	Days	If less than one day
	1	—	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Thomas
13. Birthplace Arnold, Anne Arundel Co, Md.

MOTHER
14. Maiden Name Alberta Lee
15. Birthplace Arnold, Anne Arundel Co, Md.

16 (a) Informant Mrs. Alberta Thomas
(b) Address 918 Pierce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 7, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 327 N. Christopher [illegible]

19 (a) AUG 7 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6-1945, at 5 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-6-45

VS 151

G31353 STARKey ✓ G31353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No.

Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner & Cleveland

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1924 W. Chester St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Eugene C. Starkey ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Inspector Continental Can Co.

11. Industry or business

FATHER

12. Name John Starkey

13. Birthplace Maryland

MOTHER

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Balto., Md.

18 (a) Funeral director Wm J. Freburger & Sons

(b) Address Balto. 1 Williams, M.D.

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

AUG 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945; at 1 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1945, to 8-6 1945, and that I last saw h[illegible] alive on 8-6, 19 45

Immediate cause of death Respiratory failure — Duration

Due to Bronchopneumonia

Due to

Other Conditions Cancer of the Heart Failure Old Chronic Fibrous Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Robert McBaldwin M. D.

Address West Baltimore General Hospital Date signed 8-6-45

(Over)

×

631354

BALTIMORE CITY HEALTH DEPARTMENT

631354 Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Orkney Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Orkney Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Lincoln Greiner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-5399

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband/wife Mary Greiner
6 (c) If alive, give age over 21 years

7. Birth date of deceased (mo., day, yr.) October 24 1889

8. AGE: Years	Months	Days	If less than one day
55	9	5	hr. min.

9. Birthplace Wilmington Delaware
(Town, county, and state)
10. Usual Occupation Civil Engineer
11. Industry or business Railroad

FATHER
12. Name Frederick L. Greiner
13. Birthplace Wilmington Del.

MOTHER
14. Maiden Name Nellie H Lee
15. Birthplace Delaware

16 (a) Informant Mrs Frederick L. Greiner
(b) Address 517 Orkney Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

AUG 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 1.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945, to Aug 6 1945, and that I last saw h[illegible] alive on Aug 6 1945.

Immediate cause of death Coronary Thrombosis
Duration 22 Hrs.

Due to Hypertension
Duration 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rhodes F. O'Donnell M. D.
Address 7301 York Rd Date signed Aug 7 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31355

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52 B

G31355
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Oakcrest Ave.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 223 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Oakcrest
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin H. Hoover.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Wh.	Married.

6 (b) Name of husband or wife Edna L. Hoover
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1874

8. AGE: Years	Months	Days	If less than one day
70	9	29	hr. min.

9. Birthplace Landisville, Pa.
(Town, county, and state)
10. Usual Occupation Construction.
11. Industry or business Penna. R. R.

FATHER
12. Name — ? Hoover
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Wagenost
15. Birthplace Penn.

16 (a) Informant Mrs. Edna L. Hoover
(b) Address 2903 Oakcrest Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8. 1945 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden Balto. Md.

18 (a) Funeral director Wm. J. Teikner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) AUG 7 1945 Huntington Williams, M.D. Registrar
(Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.... alive on Aug 6 19 45.

Immediate cause of death	Duration
Cardiac failure	
Due to Generalized carcinoma - Cachexia, Hemorrhage into	
Due to Bladder - Carcinoma of bladder	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-29-44
Major findings of operation: Carcinoma of Bladder.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address University Hosp. Date signed 8-6-45

X

G31356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

G31356 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 W. 40th Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ILSE Elsie Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: SIGBERT GOLDSTEIN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation N.W

11. Industry or business

FATHER
12. Name Julius —
13. Birthplace G.

MOTHER
14. Maiden Name Julia
15. Birthplace G.

16 (a) Informant Mrs. Ruth Oppenheimer
(b) Address 5710 Kingsville Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Russdale
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1429 E. Balto. St

19 (a) AUG 7 1945 (Date registered) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 7:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-9-45 at 3:30 P. M.
(b) Where did injury occur? North Avenue & Etting Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Struck by streetcar.

23. Signature Robert Le Fratar M.D.
Medical Examiner.
Date signed August 6, 1945

VS 151

G31357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 11-7B

G31357 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dekeland St
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Maisel St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence E Grace

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-10-6017

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Vivian E Grace

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1-6-1895

8. AGE: Years	Months	Days	If less than one day
50		30	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name John Grace
13. Birthplace Baltimore County Md

MOTHER
14. Maiden Name Clara Parkes
15. Birthplace Howard County Md

16 (a) Informant Rutherford Kahlein
(b) Address 2834 Westwood Ave Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Rd

18 (a) Funeral Director C.B.M. Walter
(b) Address Pratt & Stricker Sts

19 (a) (Date received by Registrar) AUG 7 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945 at 11:35 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1945 to 8-5 1945 and that I last saw him alive on 8-6 1945.

Immediate cause of death: Hemorrhage — Duration

Due to: Duodenal Ulcer

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Amos A. Donkar M. D.
Address Univ. Balto. Gen. Hospital Date signed 8/5/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G31358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Bloom St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Bloom St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Underwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1866

8. AGE: Years 79 | Months 5 | Days 19 | If less than one day - hr. min.

9. Birthplace Americus, Ga.
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Lydia Johnson
15. Birthplace Ga.

16 (a) Informant Mamie Johnson
(b) Address 502 Bloom St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Salonia A. Stallard
(b) Address 1631 Druid Hill Ave

19 (a) AUG 7 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to August 3 1945 and that I last saw h[illegible] alive on August 3 1945

Immediate cause of death	Duration
(a) Cerebral Thrombosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Wesley Wroth M. D.
Address 84 Eutaw M. Date signed Aug 4

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1186a

Registered No. G31359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bethlehem Shipyards Key Highway
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4000 Pennington Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace V. Brite

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-2792

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Celmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Rigger
11. Industry or business Beth - Fairfield Co.

FATHER
12. Name James P. Brite
13. Birthplace N.C.

MOTHER
14. Maiden Name Ida White
15. Birthplace N.C.

16 (a) Informant Mrs. Elizabeth Brite
(b) Address 4000 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Wilson, Registrar

AUG 7 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 4 at 1945 24/2 M.
(b) Where did injury occur? 1101 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fall 35' thru skylight on

23. Signature Robert Lee Fuller M.D.
Medical Examiner.
Date signed Aug. 5 1945

G31360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G31360

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Lakeside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Siebert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M

6 (b) Name of husband ~~or wife~~ Chas W. Siebert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26th 1863

8. AGE: Years	Months	Days	If less than one day
82	5	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name August Hofmeister
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Miss Emma Siebert
(b) Address 1307 Lakeside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto.

18 (a) Funeral director C. J. Feeney & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) AUG 7 - 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945, at 2:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1945, to 8/5 1945, and that I last saw her alive on Aug. 4 1945.

Immediate cause of death Cardiac Failure secondary to Carcinoma of the Recto-Sigmoid

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/2/45

Major findings of operation: Carcinoma of Recto-Sigmoid & Metastasis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 8/5/45

VS 150

X

G31361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164 C Registered No. G31361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Aliceanna St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie (Janina) Zandarski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife A. Stanislaus
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July — 1894

8. AGE: Years	Months	Days	If less than one day
51	1		hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Nun

11. Industry or business

FATHER
12. Name Frank Zandarski
13. Birthplace Poland

MOTHER
14. Maiden Name Katarzyna Domikowska
15. Birthplace Poland

16 (a) Informant Sister Martha Zandarski
(b) Address 1706 Aliceanna St

17 (a) Burial (b) Date thereof 8/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Germantown Hill Road

18 (a) Funeral director M. J. Sadowski Sons
(b) Address 1808 Eastern Avenue.

19 (a) AUG 7 1945 Huntington Williamsburg, Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound
Chest

Due to Mental

Other Conditions Mental Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 4 1945 3 P.M.
(b) Where did injury occur? 1706 Aliceanna St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Aug. 6 1945

VS 151

47 631362 8015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

631362 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 S. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eileen Saxon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-3-43

8. AGE: Years	Months	Days	If less than one day
2	-	3	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Saxon
13. Birthplace Penn

MOTHER 14. Maiden Name Dorothy Tennent
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welker
(b) Address 401 S. Chester Street

19 (Date rec'd by reg.) AUG 7 - 1945 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945, at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945 to Aug. 6 1945 and that I last saw her alive on Aug. 6 1945

Immediate cause of death	Duration
1. Circulatory or heart failure	
Due to Post operative pulmonary complications	
Due to Tetralogy of Fallot	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/1/45

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Hammond M. D.
Address Date signed

VS 150

X

G31363

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G31363
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Theresa Radtke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 / 45

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Jerome Radtke
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Pearl Marydine Wasowska
15. Birthplace Baltimore Md

16 (a) Informant Mother Pearl Radtke
(b) Address 1335 E Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 7 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Charles St

19 (a) AUG 7 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1945, at 1 18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death	Duration
atelectasis	
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

(f) Signature [illegible]
Address [illegible] Date signed 8/6/45

* correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 3

631364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

631364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence H. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Emanuel Mitchell
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lottie Dorsey
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Cooper
(b) Address 1605 Faith Lane.

17 (a) Burial (b) Date thereof 8/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 N. Eden Street

19 (a) AUG 7 (b) 1945
(Date rec'd by Registrar)

Huntington Woodlawn, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6- 1945 at 8 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-45 at 7:45 A. M.
(b) Where did injury occur? Harbor Fleet St. & Fallsway
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Found Drowned.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-6-45

VS 151

G31365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31365 Registered No. 24747

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 No Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 No. Dallas St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Albert Handy

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age 1914 years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1914

8. AGE: Years	Months	Days	If less than one day
30	11	26	— hr. — min.

9. Birthplace Cambridge, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ship construction

FATHER
12. Name Albert Handy
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Sadie Kish
15. Birthplace Cambridge Md.

16 (a) Informant Christine Goldsborough
(b) Address 935 No. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8-1945 (month) (day) (year)
(c) Cemetery or crematory Int Calvary Cemetery
Location A A Co. Md.

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

19 (a) (Signature of local registrar) (b) Registrar

AUG 7 1945
Reg. No. Huntington Hillsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945, at 8.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945, to Aug 3 1945, and that I last saw him alive on Aug 3 1945.

Immediate cause of death Tuberculosis — Duration 4 yrs.

Due to

Due to over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Renold B Lighston M.D.
Address 2129 Druid Hill Ave Date signed 8/4/45

RENOLD B. LIGHSTON M.D.

G31366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31366 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shepherd Drain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maud I Houck
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 24, 1876
8. AGE: Years 68 | Months 11 | Days 18,13 | If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Vernon C. Drain
13. Birthplace Md

MOTHER
14. Maiden Name Mary C. Hurley
15. Birthplace Md

16 (a) Informant Mrs Maud Drain
(b) Address 611 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.9.45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry A. Wilson
(b) Address 4101 Edmondson Ave

19 (a) 1945 (b) (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1945 to 8/6 1945, and that I last saw h.i.m alive on 8/6 1945.

Immediate cause of death: Cachexia — Duration
Due to: Ca of bowel c
Due to: rectal hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Haynes M. D.
Address Md. Gen. Hosp. Date signed 8/6/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G31367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31367 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 35 S. Carlton St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 35 S. Carlton St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel C. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1865

8. AGE: Years 79 Months 10 11 Days 21 If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles S. Cooper

13. Birthplace Va.

MOTHER 14. Maiden Name Virginia Cooper

15. Birthplace Va.

16 (a) Informant Mabel Kelly

(b) Address 1524 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.9.45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wyatt

(b) Address 401 E. Monument St

19 (a) (b) Registrar

Date received AUG 7 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6- 1945 at 4P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Aug 6 1945 and that I last saw h.. alive on Aug 6 1945

Immediate cause of death Odema of Lungs — Duration 2 days

Due to Cerebral Hemorrhage — Duration 1 week

Due to Arteriosclerosis — Duration

Other Conditions Hypertension — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. L. Lubstrutsky M.D.

Address 708 E North Ave Date signed 8/7/45

G31369 BALTIMORE CITY HEALTH DEPARTMENT G31369
CERTIFICATE OF DEATH 937
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Lexington
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Newton Shipley

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-22-5279

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Iva C. Shipley
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1886

8. AGE: Years 59 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Montgomery Co. Md
(Town, county, and state)

10. Usual Occupation Builder

11. Industry or business Carpentry

FATHER
12. Name Isaac Newton Shipley
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden Name Marbury Jane Pyle
15. Birthplace Montgomery Co. Md.

16 (a) Informant Mrs. Iva C. Shipley
(b) Address 1925 W. Mulberry St

17 (a) BURIAL (b) Date thereof 8/9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount ave & Oliver St

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 7 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7- 1945, at 2:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945, to Aug. 7 1945, and that I last saw him alive on Aug 6 1945.

Immediate cause of death
Cerebral Hemorrhage
(Left Hemiplegia)
Due to
Due to Chr. Myocarditis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 7/8/45
1943

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Pearl Brown
Address 1663 W. Mount Ave Date signed 8/7/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

H31369

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

H31369
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VOID - Original with this number occurred in County — Sent to State

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
		Oct. 19, 1945

6 (b) ~~Name of husband or wife~~ O'Keeman
6 (c) If alive, give age ~~If married~~ Director

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH , 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

~~Immediate cause of death~~

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

VS 150

G31370 G31370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Arlington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabel L. Brooks

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1879

8. AGE: Years 65 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Benj. M. Brooks
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary B. Brooks
15. Birthplace Balto. Co. Md.

16 (a) Informant Miss Ruth Brooks
(b) Address 2501 Arlington Ave, Balto. Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/8/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto., Md.

18 (a) Funeral director Sanders M. Brooks
(b) Address Epsom, Md.

AUG 7 1945 (Date received by registrar) Municipal Registrar Williams

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945, at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1943, to Aug 5 1945, and that I last saw her alive on Aug 5 1945.

Immediate cause of death Carcinoma of Kidney — Duration

Due to

Due to

Other Conditions Metastasis to lymphatic system
Myocarditis; Anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. V. Harbold M. D.
Address 4706 Harford Road Date signed 8/6/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G31371
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Barclay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Barclay St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah Farber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Emanuel Schwartz
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant George Farber
(b) Address 3014 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 AUG 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION 6.15

20. DATE OF DEATH August 7 1945, at A. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Autopsy or Inquiry) thereon and from the evidence obtained by said Autopsy (Autopsy or Inquiry) find that said deceased came to her death on the day stated above.

Immediate cause of death	Duration
Cerebral Concussion	
Due to Fall	
Due to Hypertension Arterio-Sclerotic cardio-vascular	
Other Conditions Disease	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/2
Accident, suicide, or homicide Accident
(b) Date of occurrence 8/7/45. 6 AM.
(c) Where did injury occur? 3014 Barclay St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs

23. Signature Dwight McNally M.D.
Medical Examiner.
Date signed 8/7/45

VS 6

G31372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

N 83a

G31372 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 Eastern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 → 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Stamoulis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-3582

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kaliope
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Xenofen Stamoulis
13. Birthplace Greece

MOTHER
14. Maiden Name Unk.
15. Birthplace Greece

16 (a) Informant August Stamoulis
(b) Address 8006 Roosvelt Ave. New York

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug. 9 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem.
Location Baltimore

18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) (b)
(day registered) Registrar

AUG 8 – 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6th 1945, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 6th 1945, and that I last saw ... alive on ... 19...

Immediate cause of death — Duration

(a) Pre-Voluntary Ordeal — 7 hrs
Due to Haemoplagia Apoplexia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wright J. Gardner
Address 3373 E. Balto St. Date signed 8/7/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Fairmont Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William James

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 1874

8. AGE: 68 yrs | Months 4 | Days | If less than one day: hr. min.

9. Birthplace Calvert County
(Town, county and state)

10. Usual Occupation farmer

11. Industry or business

FATHER
12. Name John H. James
13. Birthplace Calvert County

MOTHER
14. Maiden Name Margaret ? James
15. Birthplace Calvert County

16 (a) Informant Richard James
(b) Address 821 W Fairmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) AUG 8 - 1945 (b) Huntington Ave Baltimore, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945, at 8:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945, to Aug 6 1945, and that I last saw him alive on Aug 6 1945

Immediate cause of death Pneo. pulmonary embolism

Due to paraxysmal ventr. tachycardia

Due to

Other Conditions Vagus · Arteriosclerotic Cardio Vascular Heart Dis.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Savery M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31374
30794778

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G31374 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 11-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 Jenkins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1903

8. AGE: Years	Months	Days	If less than one day
42	5	24	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James K. Johnson
13. Birthplace North Carolina

MOTHER 14. Maiden Name Lena Little
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Holstead

18 (a) Funeral director Holstead
(b) Address 918 Herrid ave.

19 (a) (Date received) AUG 8 1945 (b) Registrar Hunting Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1945, at 9:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1945, to Aug. 3, 1945, and that I last saw her alive on Aug. 3, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. Balto. City Hosp. Date signed 8/6/45 M.D.

X

G31375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 H

Registered No. G31375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information in each space is necessary. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Waynesboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ringgold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Earl Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-45

8. AGE: Years	Months	Days	If less than one day
		18.	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Jacob Earl Kennedy
13. Birthplace Pa.

MOTHER
14. Maiden Name Ruth Sowers
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7/45 (month) (day) (year)
(c) Cemetery or crematory Brown Mills Pa
Location

18 (a) Funeral director John O. Mitchell Hyattsville Md
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS AUG 8 - 1945 Huntington for Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945, to Aug 7 1945, and that I last saw him alive on Aug 7 1945

Immediate cause of death	Duration
Uremia	
Due to ? Polycystic Kidneys (congenital)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Emerth Batson M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/7/45

X

G31376

477001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G31376 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mack Gibson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/21/05

8. AGE: Years 39 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace S. Ca. (Town, county, and state)

10. Usual Occupation House-work.

11. Industry or business

FATHER
12. Name Peter Field
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah Sawyer
15. Birthplace S. Ca.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 9 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Winsboro S. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott & Dept
(b) Address 1129 N. Caroline St.

19 (a) (b)

Registrar

AUG 8 - 1945 Burlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 6 1945, at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to Aug - 6 1945, and that I last saw her alive on Aug - 6 1945.

Immediate cause of death: Respiratory failure

Due to: Uremia

Due to: Hypertensive Cardiovascular disease

Other Conditions: Subarachnoid hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital 8/7/45

Please write plainly, with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be sure that the age is correct. Physicians: please write the causes of death clearly and legibly. The age is especially important.

13377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. 831377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 566 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Grey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-45

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Unmarried mother
13. Birthplace

MOTHER
14. Maiden Name Mary J. Grey
15. Birthplace

16 (a) Informant Martha Lee
(b) Address 566 Baker St. Balt, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 8 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1945, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1945 to 7/31 1945, and that I last saw him alive on 7/31 1945.

Immediate cause of death Pneumonia, terminal

Due to Bronchoes

Due to prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mark M. D.
Address Univ Hosp Date signed 7/31/45

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

VS 150

2892

G31378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31378

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George's Co
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 La Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Infant

6 (b) Name of husband or wife Infant

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-23-45

8. AGE: Years	Months	Days	If less than one day
1 day 0	0	1	hr. min.

9. Birthplace Fort Meade, Prince George Co
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Cpl. Baker Jones.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Margaret Jones
(b) Address 154 La Fayette St. Laurel, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 8 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1945, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945, to July 24 1945, and that I last saw h~~im~~ alive on July 24 1945

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Univ. Hosp. Date signed 7-25-45

VS 150

12891

G31379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G31379 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloun Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 936 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Daub

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced
Female | White | Widowed

6 (b) Name of husband or wife Frederick Daub
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 3rd 1865

8. AGE: Years 80 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Wilhelmina Gibson
(b) Address 1141 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director J. B. Shipley & Son
(b) Address 300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Baltimore, Md.

VS 180 AUG 8 - 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5th 1945, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945, to Aug 5 1945, and that I last saw h. ER alive on Aug 5 1945.

	Duration
Immediate cause of death General Arteriosclerosis	5 days
Due to Cerebral Hemorrhage	3 mo
Due to Myocarditis	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Elliott Duke M.D.
Address 928 E North Ave Date signed 8/7/45

G31380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31380 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Vine Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	Colored	M

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1895

8. AGE: Years	Months	Days	If less than one day
49	10	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER 12. Name Thomas Jones.
13. Birthplace Md.

MOTHER 14. Maiden Name Charlotte
15. Birthplace Md.

16 (a) Informant Mary Jones.
(b) Address 1508 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 45 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location

18 (a) Funeral director Mrs. Katie R. Willett
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 100 AUG 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4 19 45 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 19 45 to 8/4 19 45 and that I last saw him alive on 8/4 19 45.

Immediate cause of death	Duration
(a) Coronary Thrombosis	2 Hr
Due to (b) Arteriosclerosis	
Due to (c) Myocarditis	
Due to (d) Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Peckham M.D.
Address 416 N. Johnson Date signed 8/7/45

G31381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31381 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507½ N. Vincent St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 507½ N. Vincent St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1904

8. AGE: Years	Months	Days	If less than one day
40	8	12	hr. min.

9. Birthplace Howard Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Samuel Kelly
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary Matthews
15. Birthplace Howard Co., Md.

16 (a) Informant Inez Mc. Call
(b) Address 1624 N. Franklintn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie C. Wilfong
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 8 - 1945

VS. 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945 at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1944 to 8/3 1945, and that I last saw h. c. alive on 8/3 1945.

Immediate cause of death Uremia — Duration 3 wks

Due to Hypertension Cardiovascular Renal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Peckham M.D.
Address 426 N. Johnson Date signed 8/3/45

93D

631382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

631382

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1900

8. AGE: Years 45 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace Matthews Co. Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bailey Knights.
13. Birthplace Matthews Co. Va.

MOTHER
14. Maiden Name Mary Jackson.
15. Birthplace Matthews Co. Va.

16 (a) Informant Mrs. Jennie Anderson.
(b) Address 205 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8 '45 (month) (day) (year)
(c) Cemetery or crematory National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1945 at 11:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of the Aorta Spontaneous.

Due to Syphilitic Aortitis.

Other Conditions Erosion of Ribs and Lung, left.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed August 4, 1945.

VS 151

G31383
JO #80663

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31383 Registered No.
CERTIFICATE OF DEATH 30E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 4mos. 4days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1049 Brantley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Sampson ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Clinton (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1895

8. AGE: Years	Months	Days	If less than one day
49	7	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Brown (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Susie Collins (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9; 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 1118 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1945, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 30, 1945, to Aug. 4, 1945, and that I last saw her alive on Aug. 4, 1945.

Immediate cause of death	Duration
cerebro-vascular accident (hemorrhage)	
Due to arteriosclerosis and sporadic vascular disease	
Due to	
Other Conditions coronary artery sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: without as above noted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Huntington Howland M. D.
Address V.E.H. Date signed 8/7/45

X

G31384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G31384 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1037 W. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1037 W. Fayette St (If outside city or town limits, write ROUTE and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Louistown, Delaware (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Braxton
13. Birthplace Delaware

MOTHER
14. Maiden Name
15. Birthplace Delaware

16 (a) Informant William Gray
(b) Address 1037 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 1600 Schroeder St

19 (a) AUG 8 - 1945 (Date received by Registrar) (b)

Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4th 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1945, to Aug 3 1945, and that I last saw h... alive on Aug 3 1945.

Immediate cause of death	Duration
Carcinoma of liver	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Lafayette Date signed Aug 6 45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146c

✓ G31385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John & Lafayette Avenue
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 29 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Woodbridge Avenue (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Ella (Panzarella) Radausky G 29905

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John Vincent Radausky
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) March 4th 1916

8. AGE: Years	Months	Days	If less than one day
29	5	3	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant John Radausky
(b) Address 3714 Woodridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Edmondson Ave

18 (a) Funeral director Joseph Kaminska
(b) Address 604 Park Ave

19 (a) (b) Huntington Williams, M.D. Registrar

AUG 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1945, at 4 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 7th 1945, to August 7th 1945, and that I last saw h-er alive on August 7th 1945.

Immediate cause of death	Duration
Post-Partum Hemorrhage	
Due to Cervical Lacerations and extending to body of Uterus	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature For J. R. Davis, — Howard J. Moreau, M.D.
M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31386

CWK-92819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31386

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-8-
(e) Length of stay in Baltimore (yrs., mos., or days) 27-10-9

7-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Lakewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Tellis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Tellis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27-1917

8. AGE: Years	Months	Days	If less than one day
27	10	9	hr. min.

9. Birthplace Maryland, Baltimore
(Town, county, and state)
10. Usual Occupation Tool Inspector
11. Industry or business U. P. Frgt.

FATHER
12. Name Arthur Tellis
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Ritter
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 8/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) AUG 8 - 1945 Huntington Hills, Md.
(Registrar's signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6-1945 19 , at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1945, to August 6 1945 and that I last saw him alive on Aug. 6 1945.

Immediate cause of death Irremovible Surgical Shock — Duration 3 hrs

Due to Probably due to Hemorrhage

Due to

Other Conditions Pulmonary Tbc & Cavitation

(Include pregnancy within 3 months of death)

Date of operation 8-6-45

Major findings of operation: Same

of autopsy Complete cavitation RLL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in (Operation)
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-6-45 at 8:45 P M
(c) Where did injury occur? East City Hospitals
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? public While at work? No
(Specify type of place)
(e) Means of injury Surgical Shock

23. Signature A R Butler M. D.
Address 4940 Eastern Ave Date signed 8-7-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

~~FILED~~ APPROVED BY THE MEDICAL EXAMINER J. Marcin, M.D.

G31387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G31387 Registered No.

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1904 Fleet St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1904 FLEET ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula M Gerczak Getz

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: George Gerczak Getz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March.16.1900

8. AGE: Years	Months	Days	If less than one day
45	4	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business at home

FATHER

12. Name Walter L Richardson

13. Birthplace Arundel Co Md

MOTHER

14. Maiden Name Unknown

15. Birthplace Arundel Co Md

16 (a) Informant George Gerczak Getz Husband

(b) Address 1904 Fleete St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.9.1945 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cemt.

Location Lake Shore A.A. CO Md

18 (a) Funeral director Lilly Zeiler Inc

(b) Address 403 S Wolfe St

19 (a) (Date received by Registrar) AUG 8 - 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6. 1945, at 1:28 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to Aug. 6 1945 and that I last saw her alive on Aug 6 1945.

Immediate cause of death: CARCINOMA OF URINARY BLADDER — Duration: 1 YEAR.

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph F. Deanga

Address 207 S. Chester St Date signed 8/8/45 M.D.

VS 150

Registrar Williams, MD

X

1388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Caldwell St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond C. Eaves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Ethel D. Hazard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1890

8. AGE: Years	Months	Days	If less than one day
55		12	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired Fireman

11. Industry or business Balto. Fire Dept.

FATHER
12. Name Wm. Eaves
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Della C. Clemm
15. Birthplace Frederick, Md.

16 (a) Informant Raymond W. Eaves (Son)
(b) Address 510 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

AUG 8 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1945, to Aug 5 1945, and that I last saw h/ alive on Aug 5 1945

Immediate cause of death Cerebral accident — Duration

Due to Hypertension and Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robby L. Eaves M.D.
Address Franklin Square Hosp. Date signed 8-7-45

X

Please write plainly with pen and ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

631389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 c

631389 Registered No.

Physicians: please write the causes of death clearly and legibly. Any false statement, concealment, correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 O'Dell Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 O' Dell Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Virginia Strobel

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 5, 1853

8. AGE: Years 91 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Shrewsbury, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jessie Hedrick
13. Birthplace Pa.

MOTHER
14. Maiden Name Marshall
15. Birthplace Canada

16 (a) Informant Mrs. Joseph Dertinger
(b) Address 903 H. Street Balto. 19, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Balto Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1945, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Aug 6 1945 and that I last saw her alive on Aug 5th 1945.

Immediate cause of death: Acute Dilatation of the Heart — Duration 2 hrs

Due to Inflammation of Bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Wright L. Sadler
Address 3328 E Balto St Date signed 8/7/45

G31390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No. G31390

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Llewellyn Ave
(c) Hospital or institution: 9-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Lyle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Fredrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1887

8. AGE: Years 58 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Lyle
13. Birthplace Va

MOTHER
14. Maiden Name Mattie
15. Birthplace Va.

16 (a) Informant Joseph Lyle
(b) Address 2296 Matthews St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Robert A. Elliott Sr.
(b) Address 1129 N. Caroline St.

19 (a) AUG 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8·7·1945 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6·10·1945 to 8·7·1945, and that I last saw him alive on 8·7·1945

Immediate cause of death: Acute Myocard. Infarction — Duration: 1 Day

Due to: Chr. Nephritis — 3 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E. Chase Date signed 8·8·45

X

VS 130

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

631391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. Hans Hopkins Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1001 Valley St
(If outside city or town limits write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip De Powers

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 717-07-6494

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife: Mary C. Cahill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1902

8. AGE: Years	Months	Days	If less than one day
43	0	27	hr. min.

9. Birthplace: Phila, Pa.
(Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: PENN. R.R.

FATHER
12. Name: MICHAEL DE POWERS
13. Birthplace: ITALY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: ITALY

16 (a) Informant: MRS. MARY C. DEPOWERS
(b) Address: 1001 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: 4430 Belair Road

18 (a) Funeral director: Edward W. Conklin & Son
(b) Address: 924 E. Eager St.

19 (a) AUG 8 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945; at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert L. Gruber M.D.
Medical Examiner.
Date signed: Aug 7 1945

X

G31392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1358

Registered No. G31392

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 165 N Decker Ave
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 +
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 165 N Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. King

3 (b) If veteran, name war: Spanish War
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Dollie A King
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) Aug 3-1878
8. AGE: Years 67 | Months — | Days 5 4 | If less than one day ____ hr. ____ min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name George King
13. Birthplace Va

MOTHER
14. Maiden Name Virginia Mason
15. Birthplace Va

16 (a) Informant James R King
(b) Address 208 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) AUG 8 - 1945 (Date received by registrar) (b) Filed by Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945 to Aug. 7 1945 and that I last saw him alive on Aug. 7 1945

	Duration
Immediate cause of death (a) Uremia	
Hypostatic pneumonia	five days
Due to (b) Ch. Nephritis	
Due to Enlarged Prostate	
Other Conditions Bedsores	
Hypostatic pneumonia	

(Include pregnancy within 3 months of death)

Date of operation August 4 1945
Major findings of operation: Distended Bladder
of autopsy Infected Bladder + Kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Meyers M. D.
Address Mercy Hospital
Date signed 8-7-45

VS 150

G31393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31393 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or institution: St. Joseph's Hosp. 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 2306 E. Preston St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Johnson - Wachsmuth.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife Henry Wachsmuth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/70

8. AGE: Years	Months	Days	If less than one day
74	7	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Conrad Laffrau
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Reis
15. Birthplace Germany

16 (a) Informant Mrs Hazel Bankard
(b) Address 2603 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 '45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008-8 Orleans St

19 (a) Aug 8 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7/45 19 . at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/45 19 . to 8/7/45 19 , and that I last saw h alive on 8/7/45 19 .

Immediate cause of death Cerebro-vascular Accident. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Rodgers M. D.
Address St. Joseph's Hosp. Date signed 8/7/45

X

G31394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

G31394 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Any item of information not known or not obtainable, write the word UNKNOWN. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 842 N Patterson Park Ave

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 842 N P.P.Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ida Madeline Joeckel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Aug E Joeckel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12. 1872

8. AGE: Years 72 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Philip Blum

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Johannah Bohlman

MOTHER 15. Birthplace Germany

16 (a) Informant Mrs Frank Knoche

(b) Address 842 N P.P. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 E Lake ave

19 (a) Date received by Local Reg. Aug 8 1945 (b) Registrar Huntington Williams M.D.

Address 2623 E. Monument St

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945, at 11 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4. 1944 to Aug 6 1945, and that I last saw her alive on Aug 6 1945.

	Duration
Immediate cause of death: Myocardial degeneration	5 yrs.
Due to: Hyperthyroidism	1
Due to:	
Other Conditions: Arteriosclerosis generalized	1

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis F. Klemes M.D.

Date signed 8/7/45

VS 150

G31395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31395

Physicians: please write the causes of death clearly and legibly. Information must be complete and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Wheeler Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. Gunther

3 (b) If veteran, name war No

3 (c) Social Security Account No. 216-01-6132

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mada Gunther

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr) Aug 7, 1889

8. AGE: Years 55 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mailer

11. Industry or business Newspaper

FATHER
12. Name John Gunther
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Meney
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mada Gunther
(b) Address 5 N. Wheeler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Thos F. Kenny
(b) Address Hollins & Fremont

19 (a) Date received AUG 8 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945, to July 1 1945, and that I last saw him alive on July 1 1945

Immediate cause of death	Duration
Due to Coronary Thrombosis	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Reehm M. D.
Address 2145 W Balto St Date signed

For S.J.R. Davis - Howard J. Greene, M.D.

631396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

631396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. —
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 E. street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Estell Beachum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Calvin M. Beachum
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1890

8. AGE: Years	Months	Days	If less than one day
54	8	—	— hr. — min.

9. Birthplace Betterton, Kent Co., Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Leigh
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Calvin M. Beachum
(b) Address 724 E St. Sparrows Pt., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Still Pond Meth. Cem.
Location Still Pond, Kent Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Wills Registrar

AUG 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1945, at 1230 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 19 45 to Aug. 6 19 45.
and that I last saw h~~er~~ alive on Aug. 6 19 45.

Immediate cause of death	Duration
Congestive heart Failure	
Due to Hypertension	
Due to Hypertension	
Other Conditions Carcinomatosis, Bronchiectasis, (Include pregnancy within 3 months of death)	Few
Date of operation	
Major findings of operation:	
of autopsy: Pulmonary Congestion	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Union, Maryland Date signed 8/6/45

X

PLEASE WRITE PLAINLY, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Lakeside Ave
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Lakeside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Creagh Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Geraldine Adams
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) October 20, 1901

8. AGE: Years	Months	Days	If less than one day
44 (43)	9	19	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Manager of Battery Co.
11. Industry or business

FATHER
12. Name C. Walton Saunders
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Glazebrook
15. Birthplace Va.

16 (a) Informant Mrs. Geraldine A. Saunders
(b) Address 1703 Lakeside Ave., Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Hollywood
Location Richmond, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) AUG 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1945, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabiniske M.D. Medical Examiner.
Date signed 8/8/45

VS 151

631398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

631398 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Levindale
(c) Hospital or institution: Belvedere ave + Greenspring ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere ave + Greenspring (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Pressman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Late Mat

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jacob Kurek
13. Birthplace Russia

MOTHER 14. Maiden Name Deworia
15. Birthplace Russia

16 (a) Informant Mrs Gertrude Krank
(b) Address 925 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale
Location Hamilton ave

18 (a) Funeral director Sol Levinson + Bros
(b) Address 624-26 W. North ave

19 (a) (Filed by registrar) (b) Huntington, West Virginia

AUG 9 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1942 to 8-8 1945, and that I last saw h[illegible] alive on 8-8 1945.

Immediate cause of death: Cerebral hemiplegia
Hypertension, Arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin, M.D.
Address Levindale Date signed 8/8/45

X

HEP #93411 G31399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31399 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mo. 4D
(e) Length of stay in Baltimore (yrs., mos., or days) 21 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rubin Saunders

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Fannie Saunders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1894

8. AGE: Years	Months	Days	If less than one day
51	1	2	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Simon Saunders (D)
13. Birthplace Georgia

MOTHER
14. Maiden Name Addie Irvin (D)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 (month) 9 (day) 45 (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Scriggs
(b) Address 139 W. Hamburg St.

19 (a) AUG 8 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1945, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2, 1945, to Aug. 6, 1945, and that I last saw him alive on Aug. 6, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 8/7/45

G31400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1228

Registered No. G31400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Community Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Detour.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Shyrock

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Wh.	Married.

6 (b) Name of husband or wife Harvey R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/1894

8. AGE: Years	Months	Days	If less than one day
50	10	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation housewife.
11. Industry or business

FATHER
12. Name Alfred Stonesifer.
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Frock
15. Birthplace Md.

16 (a) Informant Harvey R. Shyrock
(b) Address Detour, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Keysville Cemetery
Location Keysville, Md.

18 (a) Funeral director C. O. Gist & Son
(b) Address Taneytown, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 31 19 45 to Aug 8 1945.
and that I last saw her alive on Aug 8 19 45.

Immediate cause of death	Duration
Cardiac failure	
Due to Intestinal obstruction	
Due to Postable adhesions	
Other Conditions Colostomy.	

(Include pregnancy within 3 months of death)
Date of operation Jul. 31, 1945
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Butler M. D.
Address univ. Hosp. Date signed 8-8-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150
AUG 8 - 1945 Huntington Williams, Md.

G31401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G31401 Registered No.

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and legibly. Do not abbreviate. Use only accepted medical terms. Please report date of death as well as date of operation, if any. Please report month of birth as well as age if deceased is under one year of age. Please report length of stay in hospital or institution, as well as length of stay in Baltimore, in every case. Please report length of stay in Baltimore even if deceased was born in Baltimore. Please report usual residence even if deceased died in hospital or institution. Please report business or occupation even if deceased was not employed at time of death, but had a usual occupation. Please report birthplace of father and mother even if deceased was born in Baltimore. Please report cause of death, even if deceased was not attended during last illness, if physician was in charge of case. Please report time of death in every case. Please report whether or not accident, suicide or homicide was involved, even if deceased was not attended during last illness. Please report even approximate address of informant. Please report even approximate date of burial. Please report even approximate address of undertaker. Please report even approximate date certificate was signed. Please report even approximate address of physician. Please report even approximate date of death. Please report even approximate time of death. Please report even approximate cause of death. Please report even approximate duration of each cause of death. Please report even approximate interval between onset and death. Please report even approximate contributory causes. Please report even approximate complications. Please report even approximate other significant conditions. Please report even approximate operation. Please report even approximate findings of operation. Please report even approximate autopsy. Please report even approximate accident, suicide or homicide. Please report even approximate date of occurrence. Please report even approximate where injury occurred. Please report even approximate whether injury occurred about home, on farm, industrial place, in public place. Please report even approximate means of injury. Please report even approximate while at work. Please report even approximate signature. Please report even approximate address. Please report even approximate date signature was written. Please report even approximate M. D. Please report even approximate registrar. Please report even approximate date registered. Please report even approximate VS 150. Please report even approximate Huntington Williams M.D. Please report even approximate X. Please report even approximate 1. PLACE OF DEATH: (a) Baltimore City, Maryland (b) Street address Pappas Ave & Dundalk St (c) Hospital or institution: Balto Gen Hospital 9 (d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days (e) Length of stay in Baltimore (yrs., mos., or days) 8 days 2. USUAL RESIDENCE OF DECEASED: (a) State Md (b) County 8 (c) City or town Baltimore (If outside city or town limits, write RURAL and give town) (d) Street No. 1108 E 20th St (If rural give location) (e) Citizen of foreign country? (Yes or No) If yes, name country 3 (a) FULL NAME Lany M. Carter 3 (b) If veteran, name war 3 (c) Social Security Account No. 4. Sex M 5. Color or race W 6 (a) Single, married, widowed, or divorced. 6 (b) Name of husband or wife 6 (c) If alive, give age years 7. Birth date of deceased (mo., day, yr.) 7-27-45 8. AGE: Years Months Days 11 If less than one day hr. min. 9. Birthplace Baltimore (Town, county, and state) 10. Usual Occupation 11. Industry or business FATHER 12. Name Leonard Carter 13. Birthplace N.C. MOTHER 14. Maiden Name Mary Britt 15. Birthplace N.C. 16 (a) Informant Leonard Carter (b) Address 1108 E 20th St 17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-45 (month) (day) (year) (c) Cemetery or crematory Holmes Cemetery Location Four Oaks N.C. 18 (a) Funeral director Lamborn Funeral Home Inc (b) Address 440 E North Ave 19 AUG 8 - 1945 (b) Registrar MEDICAL CERTIFICATION 20. DATE OF DEATH 7/27/45 19 , at 5 P.M 21. I certify that death occurred on the date above stated; that I attended deceased from 7/27/45 19 , to 8/2/45 19 , and that I last saw h alive on 8/2/45 19 . Immediate cause of death Peripheral failure Due to Operation on esophageal stricture Due to Congenital Other Conditions esophageal tracheal fistula (Include pregnancy within 3 months of death) Date of operation Major findings of operation: of autopsy: Duration PHYSICIAN Underline the cause to which death should be charged statistically. 22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (b) Date of occurrence at M (c) Where did injury occur? (City or town) (County) (State) (d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place) (e) Means of injury 23. Signature James A Dunbar M. D. Address Balto Gen Hospital Date signed 8/2/45 VS 150 Huntington Williams M.D. X

G31402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31402 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 Barclay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delcah Stuart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	8 23	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name E. Jones
13. Birthplace N. Carolina

MOTHER
14. Maiden Name E. Jane Whittington
15. Birthplace N. Carolina

16 (a) Informant Mrs Stuart
(b) Address 2115 Barclay st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Raleigh N. Carolina

18 (a) Funeral director S. L. Covington
(b) Address 2117 25 St.

19 AUG 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945 at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1945 to Aug 8 1945, and that I last saw her alive on Aug 2 1945.

Immediate cause of death	Duration
arteriosclerotic cardiovascular disease	
Due to	
Due to	
Other Conditions myocardial fibrosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Surgler M.D.
Address 506 E. North Ave Date signed 8-9-45

506 E. North Ave

G31403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31403

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County not known
(c) City or town Pickens (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carl Isch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed~~ or ~~divorced~~
male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 9, 1941

8. AGE: Years	Months	Days	If less than one day
4	3	29	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Benjamin Isch
13. Birthplace West Virginia.

MOTHER
14. Maiden Name Butcher
15. Birthplace West Virginia

16 (a) Informant Benjamin F. Isch
(b) Address Pickens W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 45 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Pickens W. Va

18 (a) Funeral director Harry H. Goetze
(b) Address 1401 Edmondson Ave

19 (a) AUG 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1945, at 3 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1945 to 8-8 1945 and that I last saw him alive on 8-8 1945

Immediate cause of death Cardiac failure — Duration

Due to Prolonged anoxia

Due to

Other Conditions Atelectasis of rt lung.
(Include pregnancy within 3 months of death)

Date of operation 8-8-45

Major findings of operation: Laryngeal stenosis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ Accident
(b) Date of occurrence 8-3-45 at M
(c) Where did injury occur? Pickens W. Va (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work?
(e) Means of injury Aspiration of peanut

23. Signature Eugene H. Cramer, M.D.

Address Univ. Hosp. Date signed 8-8-45

VS 150

X

G31404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No. G31404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 Sarah Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adams

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?, ?, 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business ?

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Daisy Grimms
(b) Address 737 Sarah Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

AUG 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7- 1945, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebro-vascular Renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andersen M.D.
Medical Examiner.
Date signed 8-8-45

X

631405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

Registered No. G31405

JO #24949

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1885

8. AGE: Years	Months	Days	If less than one day
60	-1-	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Preston Moore (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Charlotte ? (d)
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 9 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William J. Jackson
Address 846 Penna Ave Huntington Williams, Md

19 (a) AUG 9 - 1945 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1945, to July 31, 1945, and that I last saw him alive on July 30, 1945.

Immediate cause of death	Duration
Bronchiectasis	
Due to cause not determined	
Due to malnutrition	
Other Conditions malnutrition generalized arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 8/7/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

631406 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Jail 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 646 W Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Geo Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1893

8. AGE: Years 52 | Months 2 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Thomas Fletcher
13. Birthplace Maryland

MOTHER 14. Maiden Name Lillian Brown
15. Birthplace Md.

16 (a) Informant Edward Weir
(b) Address 822 Warner St.

17 (a) Burial (b) Date thereof Aug 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Slaton
(b) Address 1424 W Pratt St

19 (a) AUG 9 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945; at 6.4 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-5-45 at 6.45 P M.
(b) Where did injury occur? 646 W. Saratoga St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? N/A
(d) Means of injury Firearms

23. Signature Robert L Traitor M.D.
Medical Examiner.
Date signed August 7 1945

VS 151

G31407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G31407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 0 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 914 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia Berkenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace —

MOTHER 14. Maiden Name Unknown

15. Birthplace —

16 (a) Informant Edward Redman

(b) Address 2603 HILTON St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-45 (month) (day) (year)

(c) Cemetery or crematory Pikesdale

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

19 (a) [illegible] (b) Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 19 45, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Chronic nephritis, Secondary arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Wallace M.D.
Medical Examiner.

Date signed August 8, 1945.

VS 151

G31408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

G31408
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lurden and Madison
(c) Hospital or institution: Maryland General Hospital 1945
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie B. Moog
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife August Moog.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 17-1880

8. AGE: Years	Months	Days	If less than one day
65	4	20	hr. min.

9. Birthplace Easton Md (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Perry F. Daffin
13. Birthplace Md

MOTHER
14. Maiden Name Martha E. Bromwell
15. Birthplace Md

16 (a) Informant Mrs. Imogene Dikeman
(b) Address 312 S. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Dorsey Md

18 (a) Funeral director Geo. L. Boyer Jr
(b) Address 1512 Hollins St

AUG 9 - 1945 (b) Registrar
(Date rec'd by local registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7-45 19 , at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1945, to 8-6 1945, and that I last saw her alive on 8-6 1945.

Immediate cause of death ? Embolism — Duration

Due to Carcinoma of gut

Due to

Other Conditions Disorientation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jesse E. Crouch
Address Maryland General Hospital Date signed 8/9/45 M.D.

X

G31409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31409

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Dupont ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Dupont ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary a. Gleason

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Michael Gleason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 - 1860

8. AGE: Years	Months	Days	If less than one day
84	11	21	hr. min.

9. Birthplace Havre de Grace Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cornelius Maskin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Laffins
15. Birthplace Ireland

16 (a) Informant Mrs. Cornelia Callahan
(b) Address 3301 Dupont ave

17 (a) Burial (b) Date thereof 8-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Erin
Location Havre de Grace Md

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

19 (a) Filed AUG 9 1945 (b) Registrar
(Month, day, year)

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7" 1945, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1944 to Aug 7 1945
and that I last saw h er alive on July 26 1945

Immediate cause of death	Duration
Hemiplegia due to myocardial degeneration	
Due to Senility	
Due to Patient bedridden for a year or more	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Hyde
Address 1100 E Pratt St Date signed 8/9/45

Huntington Williams, M.D.

X

G31410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G31410
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate before any copies are made. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2½ S Monroe~~
(c) Hospital or institution: Sinai Hosp. 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2½ S Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Colleen [redacted] Vinyard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 - 1937

8. AGE: Years	Months	Days	If less than one day
8	1	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry J. Vinyard
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ruth E Baldwin
15. Birthplace Baltimore

16 (a) Informant Ruth E Vinyard
(b) Address 2½ S Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) AUG 9 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1945 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Aug 8 1945 and that I last saw h[illegible] alive on Aug 8 1945

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Nephrotic Stage of Glomerulonephritis
(Include pregnancy within 3 months of death)

Date of operation June 24, 1945

Major findings of operation: purulent Kidneys and sepsis

of autopsy: generalized anasarca - sudden 15 days Bronchopneumonia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnall Patz M. D.
Address Sinai Hosp Baltimore Md. Date signed 8-8-45

VS 150

G31411 ✗ ✓ G31411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
Harbor, foot of Calvert St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Caroline
(c) City or town Federalsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E Messenger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 45			hr. min.

9. Birthplace Maryland
(Town, county, and state)
Caroline County

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry B. Messenger
13. Birthplace

MOTHER
14. Maiden Name Stowell
15. Birthplace Maryland

16 (a) Informant Henry B. Messenger
(b) Address Federalsburg, Maryland

17 (a) Burial (b) Date thereof 8/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillcrest
Location Federalsburg Md.

18 (a) Funeral director J. J. Frampton & Son
(b) Address Federalsburg Md.

19 (a) AUG 9 - 1945 Huntingdon Williams, Md.
(Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6-1945 at 9 38 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Multiple fractures

Due to

Other Conditions Lacerations etc.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4/1
(a) Date of injury 8-4 ? at ? P. M.
(b) Where did injury occur? Harbor, foot of Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No ?
(d) Means of injury Found in the harbor

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-6-45

478

VS 151

✗

G31412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31412 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 E. Lombard Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JAROWSKI

3 (b) If veteran, name war -----

3 (c) Social Security Account No. -----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophie
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 12/29/82

8. AGE: Years	Months	Days	If less than one day
62	7	8	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Railroad

FATHER
12. Name ------- Jarowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Sophie Jarowski
(b) Address 1927 E. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadoski & Son
(b) Address 1808 Eastern Avenue

19 (a) (Signature) (b) Registrar

AUG 9 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 3:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Aug 1945, and that I last saw him alive on Aug 6 1945

Immediate cause of death: General Uremia, Sclerosis of Cerebral Myocardium

Duration: 2 yrs

Due to: 2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson F. Soloman, M.D.
Address 129 S. Bond Date signed 8/8/45

X

G31413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G31413 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made on this certificate and no other. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & 33rd Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5218 Springlake (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Omohundro (Lena H)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas Omohundro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1867

8. AGE: Years	Months	Days	If less than one day
87	7	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Austin B Haynes
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Strett
15. Birthplace Virginia

16 (a) Informant Mrs. Lena O. Griesemer
(b) Address 5218 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & sons
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 9 - 1945 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to Aug 8 1945 and that I last saw he alive on Aug 8 1945

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to ASHD	
Due to	
Other Conditions FRACTURED RT HIP	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 26, 1945 at A.M
(c) Where did injury occur? 5218 Springlake (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from chair at home

23. Signature J. Fred Hawkins, Jr.
Address Union Memorial H Date signed 8/8/45

VS 150 Thomas J. Williams, M.D. X

G31414 ✓ G31414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Lakeland
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Ferndale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leady (TERRY) Crawford - (George Franklin Terry)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-03-2414

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1901

8. AGE: Years 44 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Manager Palmer Garage

11. Industry or business

FATHER
12. Name Gordon Crawford
13. Birthplace Phila. Pa.

MOTHER
14. Maiden Name Hattie Terry
15. Birthplace Md.

16 (a) Informant Mrs. Hattie T. Crawford
(b) Address 3616 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

AUG 9 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1945 to Aug 8 1945, and that I last saw h.. alive on Aug 8 1945.

Immediate cause of death	Duration
Rupert Failure	
Due to Cerebral Vascular accident	
Due to Degenerative Cardio Vascular Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hypertrophy myocardium

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp. 8/8/45

VS 150

Huntington Nat'l Bank

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G31415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G31415
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caradian Ave.
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Acton Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Patrick Mc Dougall, Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mrs. Patrick Mc Dougall
6 (c) If married, widowed, or divorced, age 43 years
7. Birth date of deceased (mo., day, yr.) 10/9/1900
8. AGE: Years 44 | Months 9 | Days 28 | If less than one day hr. min.
9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Sheet metal Foreman
11. Industry or business H. C. Crook Co.

FATHER
12. Name Patrick Mc Dougall
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Allison
15. Birthplace Scotland

16 (a) Informant Mrs Hoppe Mc Dougall
(b) Address 3125 Acton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 711 Light St.

19 (a) (Date received by registrar) (b) Registrar

AUG 9 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 2:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3/45 19..., to 8/7/45 19..., and that I last saw him alive on 8/7/45 19....

Immediate cause of death — Duration
Cardiac failure
Due to
Lobar pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Rodgers M. D.
Address St. Joseph's Hosp. Date signed 8/7/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G31416 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 W. Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Linhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank Linhart

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1869

8. AGE: Years 75 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Kerka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Frank Linhart
(b) Address 925 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Mark Cruchon
(b) Address 900 W. Lexington

19 (a) AUG 9 1945 (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945, to Aug 6 1945. and that I last saw her alive on Aug 6 1945.

Immediate cause of death
Carcinoma of Stomach

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny
Address 220 E Madison Date signed 8/8/45

X

VS 150

Please write plainly, with pen and ink. Physicians: please write the cause of death clearly and legibly. Any person who wilfully makes any false statement in a certificate of death or who supplies information for the preparation of such certificate, which he knows to be false in any material fact, shall be guilty of a misdemeanor. The undertaker is required to obtain the information for items 1 to 18 and to present the certificate to the physician or coroner for the cause of death. The undertaker is required to present the certificate to the registrar for registration. The undertaker is required to present the certificate to the registrar for registration. The undertaker is required to present the certificate to the registrar for registration

631417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 631417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 W. Lafayette Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Stephens (Stevens)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Wallace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1899

8. AGE: Years	Months	Days	If less than one day
45	10	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Moorman.
13. Birthplace Howard Md.

MOTHER
14. Maiden Name Annie Carwell.
15. Birthplace Charlottesville, Va.

16 (a) Informant Henry Moorman
(b) Address 906 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St.

AUG 9 - 1945 (Date rec'd by registrar)

(b) Huntington Willis Funeral Home

MEDICAL CERTIFICATION 10

20. DATE OF DEATH August 6, 1945 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema, chronic myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mackey M.D.
Medical Examiner.
Date signed 8-7-45

VS 151

G31418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 Ogston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Ogston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Myers.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Malinda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1870.

8. AGE: Years	Months	Days	If less than one day
74	9	14	hr. min.

9. Birthplace Daisy, Howard Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Myers.
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Betty
15. Birthplace Howard Co., Md.

16 (a) Informant Malinda Myers
(b) Address 406 Ogston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, '45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
(c) Huntington Williams M.P. Regulator

AUG 9 - 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945, to Aug 5 1945, and that I last saw h[illegible] alive on Aug 5 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 Wks
Due to Arteriosclerosis	Indefinite
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley J. Woodland M. D.
Address 861 Hartman Ave Date signed 8-6-45

VS 180

X

Please write plainly; use ink; Physicians: please write the causes of death clearly and legibly. Be sure that the information given is correct and complete. Answer every question; where none, or not applicable, write "none" or "N. A." Be sure that the age is correctly stated. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G31419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31419 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Eyttleton Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Green

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wht	Married

6 (b) Name of husband or wife Dolphin Green
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) August 5, 1880

8. AGE: Years	Months	Days	If less than one day
65	--	3	....hr. ....min.

9. Birthplace Springfield Ill. (Town, county, and state)
10. Usual Occupation Pier Foreman
11. Industry or business B. & O. R.R.

FATHER
12. Name Charles Green
13. Birthplace Alabama

MOTHER
14. Maiden Name also Mary Fowlers
15. Birthplace Illinois

16 (a) Informant Mrs. Dolphin Green
(b) Address 3009 Eyttleton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Rochester
Location Springfield Ill.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

AUG 9 1945 (Date) Huntington Williams, M.D. (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1945, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1945 to 8/8 1945, and that I last saw him alive on 8/6 1945 2:30 AM

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	10 hours
Due to (b) Hypertension Cardio Vascular Disease	3 yrs +
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard T. Kurland, MD M.D.
Address Date signed 8/9/45

+ Kurland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if known. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 69
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 N. Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren Garrison Mayer

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-05-0895

4. Sex M

5. Color or race W.

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married

6 (b) Name of husband or wife Ellen E. Mayer

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept. 18-1885

8. AGE: Years 59 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Chicago Ills.
(Town, county, and state)

10. Usual Occupation Cable Tester

11. Industry or business C & P Tel Co

FATHER
12. Name Albert E. Mayer
13. Birthplace Seaford Delaware

MOTHER
14. Maiden Name Elizabeth Jane Garrison
15. Birthplace Balto Md

16 (a) Informant Vernon F. Mayer
(b) Address 1033 N. Wilton Ave

17 (a) Burial (b) Date thereof Aug 11-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Bertram Rose
(b) 2234 N. Eutaw St

19 (a) 9 AUG 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1945, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945, to Aug 8 1945, and that I last saw him alive on Aug 8 1945.

Immediate cause of death Carcinoma of Stomach — Duration 1½ Mo.

Due to (Tissue of Beginning unknown)

Due to

Other Conditions arteriosclerosis. — 3 Mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F. Kavanagh M.D.

Address 3328 McCeder St Date signed 8-9-45

VS 3

G31421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G31421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 Stiles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Stiles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Petrella

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: W. dowed
6 (b) Name of husband or wife: Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 1869

8. AGE: Years 76 | Months 1 | Days 3 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Massimino
13. Birthplace Italy

MOTHER
14. Maiden Name Mary ?
15. Birthplace Italy

16 (a) Informant Frederick Joseph Petrella
(b) Address 1017 Stiles St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. E. Dippel & Sons
(b) Address Broadway & Ann Sts.

19 (a) (Date rec'd by registrar) AUG 9 - 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945; at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/43 19 to 8/6/45 19; and that I last saw h[illegible] alive on 8/6/45

Immediate cause of death: Pulmonary Edema — Duration: 72 hrs

Due to: Heart — years ?

Due to: Organic disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. J. Emanuel, M. D.
Address Medical arts Bldg. Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G31422 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3933 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3933 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A Caldwell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1893

8. AGE: Years	Months	Days	If less than one day
51	8	17	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Martin J. Caldwell
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Kelley
15. Birthplace Maryland

16 (a) Informant Mrs. Caldwell
(b) Address 3933 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director [illegible] & Moran
(b) Address 3800 N Baltimore St

19 (a) 1945 (b) [illegible] Registrar
Rec'd by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945 to Aug 7 1945, and that I last saw h[illegible] alive on Aug 7 1945.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Secondary anaemia	3 mos
Due to Post-operative adhesions 6 mos due to ruptured gastric ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb 1945
Major findings of operation: Ruptured peptic ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Scarpulla
Address 1802 Eastern Ave Date signed 8/7/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G31423.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G31423

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Utah (b) County
(c) City or town Salt Lake City (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Third Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roger Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-33

8. AGE: Years	Months	Days	If less than one day
11	8	29	hr. min.

9. Birthplace Calif. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Burton
13. Birthplace Utah

MOTHER
14. Maiden Name Alice Beck
15. Birthplace Utah

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/45 (month) (day) (year)
(c) Cemetery or crematory
Location Bakersfield, Cal

18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1900 Eutaw Place.

19 (a) [illegible] (b) 8-9-45 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1945 at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945 to 8-8 1945 and that I last saw him alive on 8-8 1945

Immediate cause of death	Duration
Cardiac failure	
Due to congenital malformation. (radiology at Pa 11867)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-2-45

Major findings of operation: Pulmonary stenosis (angiocardiogram dem)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature W. Longmire Jr M.D.

Address J.H.H. Date signed 8-8-45

VS 150

X

G31424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31424 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4122 Parkside Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Catherine Unger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mr. Fred Unger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1887

8. AGE: Years	Months	Days	If less than one day
58	10	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Schwarz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary College
15. Birthplace Balto. Md.

16 (a) Informant Frederick W. Unger
(b) Address 4122 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Parkside Balto Co.

18 (a) Funeral director Wm. Cole Sons
(b) Address 121 Huntington Ave. Baltimore, Md.

19 (a) (Date received by Registrar) (b) Registrar

AUG 9 1945

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1945 at 12:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1945 to Aug 9 1945 and that I last saw h[illegible] alive on Aug 9 1945.

Immediate cause of death Respiratory failure

Due to Pulmonary embolism

Due to Coronary thrombosis?

Other Conditions Congestive failure

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M.D.
Address Church Home & Hosp. Date signed 8-9-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31425 ✓ G31425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Ave + Dukeland St
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J Zelinka
3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1873

8. AGE: Years	Months	Days	If less than one day
72	2	10	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Tavern

FATHER
12. Name (Unknown) Zelinka
13. Birthplace Austria

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Paul Zelinka
(b) Address 2205 Cedley St. Westport

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Oak Hill
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 9 - 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8th 7 1945 at 7.57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1945 to 8-7 1945 and that I last saw him alive on 8-7 1945

Immediate cause of death	Duration
Heart failure	
Due to cerebro-vascular accident	
Due to Hypertension	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dowker M. D.
Address W.B.G.H. Date signed 8-9-45

X DOUKER

If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31426 ✓ G31426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N Howard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter L Seema

3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-05-2693

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annabelle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 14, 1895
8. AGE: Years 49 | Months 11 | Days 23 | If less than one day: hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business R.R.

FATHER
12. Name Jesse L Seema
13. Birthplace Ohio

MOTHER
14. Maiden Name Florence Almony
15. Birthplace Md

16 (a) Informant Annabelle Seema
(b) Address 516 N Howard St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 8/9/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Thilborn & Son
(b) Address 1217 E Fort Ave

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1945, at 7:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1945 to Aug 7, 1945 and that I last saw h alive on Aug 7, 1945.

Immediate cause of death	Duration
Coronary occlusion	Immediate
Due to ✓	
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Frank H. Ogburn M. D.
Address 2701 N. Calvert St. Date signed Aug 8, 45

VS 150

Inserting for Williams, MD

X

G31427

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31427 Registered No.

CERTIFICATE OF DEATH 131B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd. Balto. Co.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Peaks (Joseph Cleveland Peaks)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1933

8. AGE: Years 12 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Ivanhoe Carroll Co. Va.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name William Floyd Peak
FATHER 13. Birthplace Va.

MOTHER 14. Maiden Name Magie Childress
MOTHER 15. Birthplace Va.

16 (a) Informant William F. Peak
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12/45 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows Cem.
Location Ivanhoe, Va.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) (Date received by Registrar) (b) Registrar
AUG 9 1945 Thurlington for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1945 at 3:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1945 to 8/9 1945, and that I last saw him alive on 8/7 1945.

Immediate cause of death	Duration
(a) Uremia & Hypertension	
Due to (b) Acute exacerbation of Chronic Glom.	
Due to (c) Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cecil Ratliff, A.B. M.D.
Address St. Agnes Hosp. Date signed 8/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G31428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Lanvale #17 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Warren H. Crampton

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 216-10-4874

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Martha Kennon
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Aug 13 1872

8. AGE: Years	Months	Days	If less than one day
72 69	11	27	hr. min.

9. Birthplace Harford Co Md (Town, county, and state)
10. Usual Occupation Sales Manager
11. Industry or business Lukens Steel Co

FATHER
12. Name Lavington Warren
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Isabella Perryman
15. Birthplace Harford Co Md

16 (a) Informant Lavington Crampton
(b) Address 214 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 '45 (month) (day) (year)
(c) Cemetery or crematory Ashcroft
Location Perryman Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

AUG 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1945, at 7 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1945 to 8/9 1945; and that I last saw him alive on 8/8 1945.

	Duration
Immediate cause of death Uremia	
Due to Hypertension C.V. Disease + Chronic Nephritis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel
Address Md. Gen'l Hospital Date signed 8/9/45 D

PLEASE WRITE PLAINLY; WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G31429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

G31429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Gier

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 27 1893

8. AGE: Years	Months	Days	If less than one day
51	8	11	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation BROOM MAKER
11. Industry or business FOR SELF

FATHER
12. Name JOSEPH GIER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name CARRIE DOBERNECK
15. Birthplace BALTO. MD.

16 (a) Informant INF. MARGARET MURRAY (SIS)
(b) Address 19 N. PATTERSON PARK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 11/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 AUG 10 1945 Huntington Williams M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1945, at 4 45- P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to

Other Conditions Edema of brain; fatty liver. Chronic nephritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. (Medical Examiner.)
Date signed 8-9-45

VS 151

G31430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93E

Registered No. G31430

PLEASE WRITE PLAINLY. With UNFADING INK. Entry must be made on typewriter or by hand printing. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 Southway
(c) Hospital or institution at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

12-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltcity.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Southway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edgar Callis

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-3900

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gladys H Callis

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25 1883

8. AGE: Years 62 | Months 0 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation President of

11. Industry or business Callis & Stammond

FATHER
12. Name Charles H Callis
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary S. Coded
15. Birthplace Baltimore Md

16 (a) Informant Howard L. Callis (bro.)
(b) Address 3004 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-11-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Morris Co.
(b) Address 108 W North Ave.

19 (a) (Date rec'd by registrar) AUG 10 1945 (b) Huntington Williamsport Md

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 8 1945 and that I last saw him alive on Aug 4 1945

Immediate cause of death: Acute congestion — Duration

Due to: heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation ✓

Major findings of operation: ✓

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature L. J. Worley M. D.
Address 110 E North Ave Date signed Aug 8 45

X

G31431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46c

G31431 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Stoneleigh (If outside city or town limits, write RURAL and give town)
(d) Street No. 7110 Sheffield Rd. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Leist.

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. 212-03-5252

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Thiel Leist
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/15/94

8. AGE: Years 50 | Months 9 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Equitable Life Assurance Soc

FATHER
12. Name Frederick Leist
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma V. Yoe
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Florence Thiel Leist
(b) Address 7110 Sheffield Rd. Stoneleigh

17 (a) Druid Ridge (Burial, cremation, or removal) (b) Date thereof August 11-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) AUG 10 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1945 at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1945 to 8-9 1945 and that I last saw h[im] alive on 8-9 1945

Immediate cause of death: Cardio-respiratory Failure — Duration

Due to Cachexia + Malnutrition

Due to Intestinal obstruction from Carcinoma of Duodenum.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-27-45

Major findings of operation: Ca. of duodenum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Rulon M.D.
Address 1700 N Calvert St. Date signed 8-9-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

HEP #95068 G31432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G31432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before it is filed. Do not write in spaces marked "For Registrar Only." Please see that your answer to each question is complete and correct as far as known. Where there is no entry, write NONE. Where the answer is unknown, write UNKNOWN. Where the question is not applicable, write NOT APPLICABLE. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days 68-1-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 No. Monroe St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Cassidy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) July 3rd 1877

8. AGE: Years	Months	Days	If less than one day
68	1	6	hr. min.

9. Birthplace Maryland Baltimore. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Cassidy
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Crockard
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Frederick Ave

18 (a) Funeral director John F. Cowen & Son
(b) Address 901 & 903 Hollins St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1945, 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 29, 1945, to Aug. 9, 1945, and that I last saw him alive on Aug. 9, 1945.

Immediate cause of death: Hemorrhage from GI tract — Duration: ?
A result of tumor — 1
Due to Erythroyeal vomit — ?
Cirrhosis of liver — ?
Due to Chronic alcoholism — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 8-9-45

X

G31433

HEP #95015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31433 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Every item must be answered. Use figures where possible. Be sure to give the information required for each item. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Krygor (Marcyanna) or Krygier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1877

8. AGE: Years	Months	Days	If less than one day
67 68	11	2	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name John Boone

13. Birthplace Poland

14. Maiden Name Mollie ??

15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Record

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 45. (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem.

Location Dundalk Avenue

18 (a) Funeral director John J. Duda

(b) Address 2829 Eastern Street

19 (a) AUG 10 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1945, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1945 to Aug. 9, 1945. and that I last saw him alive on Aug. 9, 1945.

	Duration
Immediate cause of death: Cardiac Failure	15 min
Due to: Diabetes mellitus	15 yrs
Due to:	
Other Conditions: Gangrene of toes (Include pregnancy within 3 months of death)	2 mo

Date of operation 8-5-45

Major findings of operations: Gangrene due to Diabetes m.

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Donnelly M. D.

Address Balto City Hospitals Date signed 8-9-45

Huntington Williams MD

X

G. 42595 G31434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G31434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Mullen Ave St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-43

8. AGE: Years	Months	Days	If less than one day
	5 6	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Houston Byrd
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Newby
15. Birthplace Virginia

16 (a) Informant Parents
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Brantley Lane

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945 to 8-7 1945, and that I last saw h alive on 8-7 1945

Immediate cause of death Septicemia

Due to otitis media, mastoiditis, pneumonia

Due to

Other Conditions Diarrhea

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Everett Barton M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/12/45

G31435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G31435

CWK-95189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4- 3- 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Turner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1941

8. AGE: Years	Months	Days	If less than one day
4	3	15	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eugene John Turner
13. Birthplace Maryland

MOTHER
14. Maiden Name Bernadina Turner
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bloomfield Ave

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 7 1945 at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1945, to Aug. 7 1945, and that I last saw him alive on Aug. 7 1945.

Immediate cause of death	Duration
Meningitis	?
Due to ?	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
~~Major findings of operations~~ Tuberculosis
Meningitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Bayhutt M. D.
Address Balt. City Hosp. Date signed 8/8/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A39739 5-2 G31436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B G31436 File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

5-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

11

3 (a) FULL NAME James Sykes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-24-44

8. AGE: Years	Months	Days	If less than one day
	9	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Jane Sykes
15. Birthplace North Carolina

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location AUG 10 1945

18 (a) Funeral Director Leroy A. Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945 at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1945 to 8-6 1945 and that I last saw him alive on 8-6 1945

Immediate cause of death: Miliary TBC — Duration: poor

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Gorham Jr M.D.
Address JHH Date signed 8/6/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31437 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: Henry Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Calvert
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Powell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Margaret Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Charlotte, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Margaret Powell
(b) Address 208 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1800 Bentley Ave

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 19 45 at 10:25 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 8/13/45

VS 151

G31438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G31438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days) 17 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Jarrettsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ~~Jacob Andrew~~ Mary Alice Baker. Mary alice Bahr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Jacob Andrew Baker
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) August 27, 1860

8. AGE: Years	Months	Days	If less than one day
84	11	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Henry Bay
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Watt
15. Birthplace Md

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 12-45 (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Madonna Harford Co Md
18 (a) Funeral director Marion E Hertz
(b) Address Jarrettsville Md
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul. 23 1945, to Aug. 9 1945, and that I last saw her alive on Aug. 9 1945

Immediate cause of death	Duration
bronchopneumonia	
Due to circulatory collapse	
Due to cardiac failure	
Other Conditions post-operative (resection of cecum)	

(Include pregnancy within 3 months of death)
Date of operation Aug. 3, 1945
Major findings of operation: Carcinoma of cecum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick Jr M.D.
Address Union Memorial Hosp. Date signed 8-10-45

VS 150 AUG 10 1945

G31439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31439 Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Do not leave any blanks. If unknown or not applicable, write "unknown" or "N. A." Physicians: please write the causes of death clearly and legibly. Certificate must be filed with the Registrar within 5 days after death. Burial permit will not be issued until certificate is filed. Please report promptly. Delay may result in prosecution. Please answer all questions. Information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 McElderry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Adeline Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Charles L. Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/1898

8. AGE: Years	Months	Days	If less than one day
47	6	4	hr. min.

9. Birthplace Lynchburg Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jeff Embanks
13. Birthplace Virginia

MOTHER
14. Maiden Name Rose Brown
15. Birthplace Virginia

16 (a) Informant Mrs. Geraldine Allen
(b) Address 2219 Federal St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 14 45 (month) (day) (year)
(c) Cemetery or crematory Location Lylalsing, Pa.

18 (a) Funeral director Charles R. Low
(b) Address 802 Madison Avenue

19 (a) AUG 10 1945 Registrar
VS 150 Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1945, to 8.9 1945, and that I last saw her alive on 8.7 1945

Immediate cause of death	Duration
Carcinomatosis	
Due to	
Carcinoma - intestinal	unk
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Brown X
Address 1500 E. Madison St. Date signed 8/10

G31440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G31440

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Bal.

(c) City or town Silver Beach

(If outside city or town limits, write RURAL and give town)

(d) Street No. —

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME GALLAGHER, John H.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lucille Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1874

8. AGE: Years	Months	Days	If less than one day
71	6	2 11	hr. min.

9. Birthplace Lamont Brook (Town, county, and state)

10. Usual Occupation Eng. - Dock

11. Industry or business

FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant Howard Gallagher

(b) Address 762 S. Fort Ave. 8-4-45

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Brooklyn Md

18 (a) Funeral director Frank L. McKaddy

(b) Address 760 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Md

AUG 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1945, to 8/6 1945, and that I last saw h[illegible] alive on 8/4 1945

Immediate cause of death	Duration
Respiratory & Heart Failure	
Due to Uremia	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas J. Bourne

Address Univ. Hosp. Date signed 8/9/45 M D

X

G31441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 E. Monument Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 E. Monument Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1894

8. AGE: Years	Months	Days	If less than one day
51	7	8	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Thomas Jefferson

13. Birthplace Md

MOTHER 14. Maiden Name Mather Terry

15. Birthplace Md

16 (a) Informant Albert Jefferson

(b) Address 949 N Eden St

17 (a) Burial (b) Date thereof 8-13-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Md

18 (a) Funeral director Mrs Frances A Handy

(b) Address 578 W Biddle St.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

AUG 10 1945

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1945, at 3:45 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.

Date signed 8-9-45

G31442

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G31442 ✓ 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave + Dukeland St
(c) Hospital or institution: West Baltimore General Hosp 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 10days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S. East ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Jensen ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 - 45

8. AGE: Years	Months	Days	If less than one day
1		10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Jensen
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Ann Trabert
15. Birthplace Balto Md

16 (a) Informant Father
(b) Address 36 S. East ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10th 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Cipitone
(b) Address 2818 E. Balto st.

19 (a) AUG 10 1945 Huntington Williams M.D. Registrar
(Registered by)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1945, to 8-9 1945 and that I last saw him alive on 8-9 1945

Immediate cause of death hemorrhagic disease of the Newborn — Duration

Due to

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jenny A. Dunbar M. D.
Address Univ. Balto. Hospitals Date signed 8/9/45

161C

VS 150

G31443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31443 Registered No. 1190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) If hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Turner Station
(If outside city limits, write RURAL and give town)
(d) Street No. 420 Wheeler Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarista Wright

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 / / 44

8. AGE: Years	Months	Days	If less than one day
	9		hr. min.

9. Birthplace Md. (Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Tho. Wright
13. Birthplace —

MOTHER
14. Maiden Name Mary Nichols
15. Birthplace Md

16 (a) Informant Mary Wilson
(b) Address 420 Wheeler Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Presstman St Huntington Williams, M.D.

19 (a) (Date received by registrar) AUG 10 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1945, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Greene M.D.
Medical Examiner.
Date signed August 8, 1945.

G31444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31444 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Leverton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Leverton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Bodine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie Bodine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4 - 1869

8. AGE: Years	Months	Days	If less than one day
75	9	4	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Wm. Bodine
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Smith
15. Birthplace Germany

16 (a) Informant Minnie A Bodine
(b) Address 3407 Leverton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11-45 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location E Fornwell St.

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 (a) AUG 10 1945 (b) (Registrar)
Huntington Avenue, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1945 at 6 a m M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to Aug 8 1945, and that I last saw deceased alive on Aug 8 1945

Immediate cause of death	Duration
Due to Acute Cardiac Dilation	Aug 6 45
Due to Pulmonary Infarction	4/7/45
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Bodine M. D.
Address 801 N Carrollton Ave Date signed Aug 10 45

G31445

McROY ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G31445

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary McRoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1906

8. AGE: Years	Months	Days	If less than one day
39	5 6	13	hr. min.

9. Birthplace Hydesville Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Lucy Holmes (friend)
(b) Address 110 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Filed AUG 10 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5 1945 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945 to 8/5 1945 and that I last saw h[illegible] alive on 8/1 1945

Immediate cause of death Carcinoma Uterus, — Duration 5 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. McKelvey
Address 1 W. Preston Date signed 8/7/45

Dr H. B. McKelvey - Edward J. Madden, M.D. X

PLEASE WRITE PLAINLY, with unfading black ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G31446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

✓ G31446 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Long Long

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-1226

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10. 1908

8. AGE: Years 36 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Balto (Town, county and state)

10. Usual Occupation Engineer. Helper

11. Industry or business Kemp Mfg. Co.

FATHER 12. Name Charles Long

13. Birthplace Balto

MOTHER 14. Maiden Name Anna Vinnegar

15. Birthplace Austria

16 (a) Informant Irene Blitzer

(b) Address 611 N. Decker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location Balto

18 (a) Funeral director Wm Cook Inc

(b) Address 217 St Paul St

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

AUG 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1945 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945 to 8-9 1945.
and that I last saw him alive on 8-9 1945.

Immediate cause of death

acute Cardiac Failure

Due to Chronic Glomerular Nephritis

Due to Cirrhosis of Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson

Address St. Josephs Hosp. Date signed 8-9-45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G31447

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 East Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Magri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Matilda Magri
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1887

8. AGE: Years 58 | Months 4 | Days 21/20 | If less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Welders Helper
11. Industry or business Ship Building Co.

FATHER 12. Name Samuel Magri
13. Birthplace Italy

MOTHER 14. Maiden Name Concettina Bologna
15. Birthplace Italy

16 (a) Informant Matilda Magri
(b) Address 2002 E. Eager St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Francis Bracklow
(b) Address 900 W. Lafayette Ave

19 (c) AUG 10 1945 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 19 45 at 9:30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 8-9-45 at 4:30 P. M. 24/2
(b) Where did injury occur? Harbor - Baltimore Co. Primary - Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Found Drowned.

23. Signature Howard J. Headen M.D.
Medical Examiner.
Date signed August 14, 1945

Correct age in especially important. Physicians: please write the cause of death clearly and legibly.

G31448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

G31448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lee Mae Stukes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1935

8. AGE: Years 9 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Sumter S.C. (Town, county, and state)

10. Usual Occupation School child

11. Industry or business

FATHER
12. Name George Stukes
13. Birthplace Sumter S.C.

MOTHER
14. Maiden Name Mattie Colvin
15. Birthplace Sumter S.C.

16 (a) Informant George Stukes
(b) Address 419 W. Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-12-1945 (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Baltimore County md

18 (a) Funeral director Joseph A. Lively
(b) Address 4 1901 Mount Street

19 (a) AUG 10 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1945, at 8 10 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, traumatic

Due to

Other Conditions Crushed head & chest. Multiple fractures & contusions etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/2

(a) Date of injury 8-8-45 at 7 20 P. M.

(b) Where did injury occur Eutaw & Lee Street

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Struck by freight train

23. Signature Huntington Williams M.D. Medical Examiner.

Date signed 8-9-45

X

G31449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

✓ G31449 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2639 N CHARLES STREET.
(c) Hospital or institution: NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 N CHARLES STREET. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH E. GIBBONS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife *****
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *****

8. AGE: Years	Months	Days	If less than one day
About 70	?	?	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Thomas Gibbons
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Cahill
15. Birthplace Ireland

16 (a) Informant Mary A. Gibbons
(b) Address 2639 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

AUG 10 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 8 1945 19 at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 30 1945 to AUG 8 1945 and that I last saw HER alive on AUG 8 1945.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS JULY 30	1945.
Due to ARTERIOR SCLEROSIS AUG 6	1943
Due to CHRONIC INTERSTITAL NEPTHRITIS	1943
Other Conditions (PARALYSIS 1943. NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. F. Chantrice M.D.
Address 3013 ST PAUL STREET Date signed AUGUST 8 1945

PLEASE WRITE PLAINLY, WITH INK AND AS BRIEFLY AS POSSIBLE. Do not abbreviate. Give full name of deceased. Do not use initials. Give street address or location. Be sure that cause of death is stated correctly and that date of occurrence is given. Do not report "Old Age" as cause of death. Be sure that age is especially important. Physicians: please write the causes of death clearly and legibly.

G31450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G31450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loudon & Green Sts
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tydings on the Bay
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (ROBERT GODDARD) Dr. Robert Hutchings Goddard P.H.D. & S.C.D.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Esther C. Kist Goddard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1882

8. AGE: Years 62 | Months 10 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Worcester, Mass.
(Town, county, and state)

10. Usual Occupation Director Of Research

11. Industry or business Bureau of Areonautics *Navy Dept.

FATHER
12. Name Mahun D. Goddard
13. Birthplace Mass

MOTHER
14. Maiden Name Fannie Louise Hoyt
15. Birthplace Mass

16 (a) Informant Mrs. Esther C. Goddard
(b) Address Tydings on the Bay

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Hope Cemetery
Location Worcester, Mass

18 (a) Funeral director Wm. J. Tickner & Sons, Inc
(b) Address North & Pa. Aves. Balto. 17

(a) Date received by registrar AUG 10 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1945 at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 1945 to 8-10 1945 and that I last saw him alive on 8-10 1945.

Immediate cause of death Cardiac failure — Duration

Due to Ch. myocardial disease

Due to Arteriosclerotic CVD

Other Conditions Astro Pulmonary Tbc Laryngectomy (old) for Ca of Larynx
(Include pregnancy within 3 months of death)

Date of operation June 19, 1945

Major findings of operation: Ca of Larynx

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene A. Hammar, Md. M. D.
Address Univ. Hosp. Date signed 8-10-45

×

G31451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G31451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Bradley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde Gilford Walker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Addie Walker
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) April 10, 1918

8. AGE: Years 27 | Months 3 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Walker
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Rumley
15. Birthplace Va.

16 (a) Informant Rebecca Johnson
(b) Address 829 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 AUG 11 1945 (Date rec'd) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1945 at 4 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ☐ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-45 at 4 P.M. M.
(b) Where did injury occur In front of 829 Bradley
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed with butcher knife

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-7-45

VS 151

G31452
HEP #95203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31452
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Where none, write "None." Where unknown, make a definite statement to that effect. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 94 - 5 - 23 94Y5M23D

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3912 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E Marriott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife ? ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1851

8. AGE: Years	Months	Days	If less than one day
94	5	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ? ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore City

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) Filed by registrar (b) Huntington Wilkerson, M.D.

AUG 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9th 1945, at 5:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3rd, 1945 to Aug. 9th, 1945, and that I last saw him alive on Aug. 2, 1945

Immediate cause of death	Duration
Generalized Carcinomatosis	5 yr.
Due to	
Due to	
Other Conditions Arterio-sclerotic cardiovascular disease	over

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas D. Orrell M. D.
Address Balto City Hosp Date signed 8-10-45

X

G31453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G31453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1411 E.Lafayette Avenue
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 E.Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Phillips

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary E.DeLacy
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Nov. 7th, 1856

8. AGE: Years: 88 | Months: 9 | Days: 1 | If less than one day: ###hr. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired (Laborer)

11. Industry or business

FATHER
12. Name: Charles Phillips
13. Birthplace: England

MOTHER
14. Maiden Name: Mary Hunter
15. Birthplace: Annapolis, Md.

16 (a) Informant: Mrs. Grace Garvey (Daughter)
(b) Address: 1411 E.Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: E.North Avenue, Balto; Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8th 1945, at 6 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945 to Aug. 8 1945, and that I last saw h.. alive on Aug. 8 1945.

Immediate cause of death: Cer. Thrombosis, Coronary Sclerosis

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: Interstitial

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5707 Belair Rd Date signed 8-9-45

G31454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G31454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1210 E. Biddle Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1210 E. Biddle Street (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Etta M. Fales

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William G. Fales

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1888

8. AGE: Years: 57 | Months: 5 | Days: 28 | If less than one day: ####### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER

12. Name: William P. Mattern

13. Birthplace: Pennsylvania

MOTHER

14. Maiden Name: Susan Fester

15. Birthplace: Pennsylvania

16 (a) Informant: Howard F. Fales (Son)

(b) Address: 5205 Leeds Ave Balto, Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn

Location: Eastern Ave. Balto; Md

18 (a) Funeral director: George J. Ruth, Inc.

(b) Address: 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 11 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1945 to Aug 9 1945, and that I last saw her alive on Aug 9 1945

Immediate cause of death: Hypostasis, Heart Disease — Duration: indefinite

Due to: Senility — Duration: indefinite

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: George Ruth

Address: 4808 Harford Rd. Date signed: 8/10/45

321146 G31455

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13

G31455 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-24

8. AGE: Years 21 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Mitchell
13. Birthplace ~~New York~~ Conn.

MOTHER
14. Maiden Name Margaret Casalea
15. Birthplace Pennsylvania

16 (a) Informant Uncle
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) TRANSIT Burial (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory Sharon Cem.
Location Sharon Conn.

18 (a) Funeral director L. J. Ryck
(b) Address 530 S Hartford Rd

19 (a) (b)
Date rec'd by local reg. AUG 11 1945 Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1945 at 3 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1945 to 8-10 1945 and that I last saw h alive on 8-10 1945

Cause	Duration
Immediate cause of death: Tuberculous Pneumonia	10 days
Due to: Spread from upper lobe Tbc.	1½ yrs.
Due to: Thoracoplasty	1½
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug 1, 1945
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Langmuir Jr. M.D.
Address Johns Hopkins Hosp. Date signed 8/10/45

X

G31456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G31456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 MO.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Miles Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LINDA ELIZABETH HARRINGTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1945

8. AGE: Years	Months	Days	If less than one day
—	2	11 10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation D
11. Industry or business —

FATHER
12. Name JOHN C. HARRINGTON
13. Birthplace GEORGIA

MOTHER
14. Maiden Name BEATRICE GRAY
15. Birthplace NORTH CAROLINA.

16 (a) Informant MOTHER.
(b) Address

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) AUG 11 1945 (Date received by Registrar) Registrar
Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1945 at 3:03 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Aug 10 1945 and that I last saw h[illegible] alive on Aug 10 1945.

Immediate cause of death	Duration
Acute Nutritional Diarrhea.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizedek Spraguis M. D.
Address U. M. H. Date signed 8-10-45

X

CUK-92645 G31457

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31457

CERTIFICATE OF DEATH 13B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- 19
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Dallas Street (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lillie Ross

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Charles Ross
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 28-1912

8. AGE: Years	Months	Days	If less than one day
33	4	10	..... hr. ..... min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name John Bishop
13. Birthplace ??

MOTHER
14. Maiden Name Mattie Perkins
15. Birthplace Georgia

16 (a) Informant Records-Balto. City Hospitals
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location .....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 E. Fayette and Huntington Ave, Balto, Md

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

AUG 11 1945

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Agust 8 1945, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19 1945, to Aug. 8 1945, and that I last saw her alive on Aug. 8 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Miliary Tuberculosis	?
Due to	.....
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation ..... of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Herbert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 8/9/45

359425 631458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

631458 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Low Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Glen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Anna Glen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1901

8. AGE: Years	Months	Days	If less than one day hr.	min.
44	7	16		

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Express driver

11. Industry or business

FATHER
12. Name Paint Glen
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lula Lamb
15. Birthplace South Carolina

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)

(c) Cemetery or crematory
Location Charlotte N. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bedford St. Washington Blvd.

19 (a) AUG 11 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1945 at 2-P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1945 to 8-10 1945 and that I last saw h[illegible] alive on 8-12 1945

Immediate cause of death	Duration
Subarachnoid Hemorrhage	3 days
Due to Hypertensive Cardio-Vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Graham A. Kerr M.D.
Address Johns Hopkins Hosp. Date signed 8/13/45

VS 150

G31459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Norwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Norwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bandiere

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary Bandiere
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18 1863

8. AGE: Years	Months	Days	If less than one day
81	9	22	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired Stonemason
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Charles M. Bandiere
(b) Address 4703 Norwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry A. Cannard
(b) Address 4204 Ridgewood Ave

19 (a) AUG 11 1945 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1945, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/3 1945, to Aug. 9 1945. and that I last saw h.im alive on Aug. 8 1945.

Immediate cause of death
1) - Cerebral Hemorrhage. — Duration 15 min.
2) - Arterio Sclerosis — 5 yrs.?
Due to Heart Disease
Due to
Other Conditions - Hypertension — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: - None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M.D.
Address 4108 Liberty Hts. Date signed 8/10/45

X

G31460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G31460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4805 Gwynn Oak Ave
(c) Hospital or institution: 28

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Newton

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-07-6118

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara Kane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Real Estate Salesman
11. Industry or business

FATHER
12. Name Phillip E. Newton
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sophia Glass
15. Birthplace Cambridge, Md.

16 (a) Informant Mr. Wm. E. Newton
(b) Address 4805 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof 8/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received by registrar) (b) Registrar of Vital Statistics

AUG 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 19 45 to Aug 9 19 45, and that I last saw h alive on Aug 9 19 45.

Immediate cause of death Acute Myocardits — Duration one week
Due to Endocarditis — Duration weeks
Due to Coronary Sclerosis — Duration years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Klosner, M.D.
Address 401 Edmondson Ave Date signed 8/10/45

X

G31461

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G31461 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Last
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice W. Bayliss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or ~~wife~~ Charles H. Bayliss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1883

8. AGE: Years 62 | Months 2 3 | Days 29 | If less than one day hr. min.

9. Birthplace Nightmute Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Zackariah Lorrick
13. Birthplace Rock Enon Virginia
14. Maiden Name Sarah J. Wilson
15. Birthplace Rock Enon Virginia

16 (a) Informant Charles H. Bayliss
(b) Address 2815 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron Mem.
Location Winchester Va.

18 (a) Funeral director Maurice Cook Bayliss
(b) Address 1600 W. North Ave Baltimore

19 (a) (Date rec'd by registrar) AUG 14 1945 (b) Huntington Nitro, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945, to Aug. 9 1945, and that I last saw h[illegible] alive on Aug. 9 1945.

Immediate cause of death Coronary

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Generalized Carcinomatosis

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sophie L. Cowen M. D.
Address Franklin Square Hosp. Date signed 8/10/45

X

G31462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Hanover
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Wellham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ada Wellham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1887

8. AGE: Years	Months	Days	If less than one day
58	1	—	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Truck Farmer, Shipping Foreman
11. Industry or business

FATHER
12. Name George W. Wellham
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Warfield
15. Birthplace Md.

16 (a) Informant Daughter
(b) Address Hanover, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Williams Cem.
Location Hanover

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (State fact on which signed) (b) Huntington Williams, M.D. Registrar

AUG 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/45 19 , at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1945, to 8-10 1945, and that I last saw h[illegible] alive on 8-10 1945 2 P.M.

	Duration
Immediate cause of death Uremia	3 days
Due to ? Pyelonephritis Left	2 yrs
Due to	
Other Conditions Infected hydatitis cirrhosis of liver	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard T. Kurland M. D.
Address University Hospital Date signed 8/10/45
133a Kurland

G31463

AB-93635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G31463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-24days

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1826 Eastern Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Laszcynski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 54	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business

FATHER 12. Name Sylvester Laszcynski

13. Birthplace Poland

MOTHER 14. Maiden Name Helen Zawacka

15. Birthplace Poland

16 (a) Informant Teresa Laszcynski

(b) Address 1826 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Balto Co

18 (a) Funeral director W. S. Fialkowski

(b) Address 2007 Eastern Ave

19 (a) Filed AUG 11 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8- 1945, at 1.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15- 1945, to 8-8- 1945 and that I last saw h im alive on 8-8- 1945

Immediate cause of death	Duration
Cerebral Thrombosis	?
Due to Polycythemia Vera	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature T. P. Gerrigan M. D.

Address Baltimore City Hosp Date signed 8-8-45

X

G31464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31464
Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Do not use abbreviations. Do not leave any blanks. Use "None" or "Unknown" where applicable. Do not use ditto marks. Be sure to answer each question. Please give information requested as to occupation, residence, birthplace, etc., of each person even though deceased was not employed at time of death. Physicians: please write the causes of death clearly and legibly. Be sure to fill in items 16 and 17 and to sign certificate. Please report at once any error or omission you may find in this certificate. Please see that certificate is correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Beaufort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Beaufort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M Garrett

3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Edwin L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-13-1877

8. AGE: Years 67 | Months 7 | Days 23+ | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation home mfr
11. Industry or business

FATHER
12. Name John Briley
13. Birthplace unknown

MOTHER
14. Maiden name Mary E Jones
15. Birthplace unknown

16 (a) Informant Miss Alice Bosley
(b) Address 3707 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 W 36 St

19 (a) AUG 11 1945 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1945 at 1150 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1939 to Aug 10 1945, and that I last saw her alive on Aug 9 1945:

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs
Due to Hypertensive CVD	?
Due to	
Other Conditions Diabetes	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J Linnard M. D.
Address 3741 Falls Rd Date signed 8-10-45

930

G31465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G31465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland and Raymer Sts.

(c) Hospital or institution West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1822 Mc Henry St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ~~John Bunch~~ ARCHIE J. BUNCH

3 (b) If veteran, name war None

3 (c) Social Security Account No. 408-22-9238

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married.

6 (b) Name of husband or wife BELLE Bunch

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 4, 1883

8. AGE: Years	Months	Days	If less than one day
62	4	0	hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation

11. Industry or business Ship Yard

FATHER — 12. Name	Allen Bunch
FATHER — 13. Birthplace	Kentucky
MOTHER — 14. Maiden Name	Sarah B. Haynes
MOTHER — 15. Birthplace	Kentucky

16 (a) Informant Lizzie Jefferies

(b) Address Jellico Tenn.

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Aug. 11-1945 (month) (day) (year)

(c) Cemetery or crematory

Location Jellico Tenn.

18 (a) Funeral director Robt C & B. M. Walter

(b) Address Watts Street

19 (a) ~~AUG 11 1945~~ (b) Registrar Assisting for Williams Mc

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 1:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 1945, to August 11 1945, and that I last saw him alive on August 9 1945.

Immediate cause of death, Respiratory failure

Due to Bronchopneumonia

Due to Intestinal obstruction due to adhesions

Due to Congestive Heart failure Pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/5/45

Major findings of operation: Adhesions about large colon

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address Med Bldg Baltimore General Hosp. Date signed 8/11/45 M. D.

G31466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G31466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Bleeker Street

(b) Street address 123 W. Hamberg St.

(c) Hospital or institution: University Hospital 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 123 W. Hamberg St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Yvonne Marie Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race B.

6 (a) Single, married, widowed, or divorced. Defacto

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/16/1945

8. AGE: Years 2 Months 3 Days 24 If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Melvin Hughes

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Naomi Vanlaughan

15. Birthplace Baltimore Md

16 (a) Informant Naomi Hughes

(b) Address 1236 Hamberg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11. 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A.A. Co., Md

18 (a) Funeral director Isaac R Brown Son

(b) Address 1080 Montgomery Street

19 (a) (Date rec'd by registrar) AUG 11 1945 (b) Huntingtown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945 at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Aug 9. 1945 and that I last saw her alive on Aug 9 1945

Immediate cause of death	Duration
Decapitating fracture	
Due to acidosis, severe	
Due to dehydration, severe diarrhea, severe	
Other Conditions Possible Pneumonia Right base	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Meredith Gregg Clark M. D.

Address Greene + Lambert Date signed 8-9-45

G31467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

G31467

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1047 N. Saratoga Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Reader Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 15, 1887

8. AGE: Years 57 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Columbia S. C.
(Town, county, and state)

10. Usual Occupation Transfer Hack

11. Industry or business

FATHER
12. Name Porter Smith
13. Birthplace Columbia, S. C.

MOTHER
14. Maiden Name Patsy
15. Birthplace Columbia, S. C.

16 (a) Informant Mrs. Reader Smith
(b) Address 1047 N. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion
Location Montgomery Co. Md.

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) AUG 11 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1945, at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia
Acute Pancreatitis
Due to Fractured Pelvis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 18/2
(a) Date of injury 7-16-45 at 6 P. M.
(b) Where did injury occur? 1047 N. Saratoga St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home - Rear - While at work? No
(d) Means of injury Struck by automobile

23. Signature Howard D. Gleaves M.D.
Medical Examiner.
Date signed August 10, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31468 ✓ 631468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond + Green Sts.
(c) Hospital or institution: University Hospital 18 1/2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 W. Lexington St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3 (a) FULL NAME Ronald Brown ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	Infant

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 20, 1945

8. AGE: Years	Months	Days	If less than one day
—	4	19	_____ hr. _____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation _____
11. Industry or business _____

FATHER
12. Name William Brown
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Alberta Carter
15. Birthplace Baltimore Md.

16 (a) Informant Alberta C. Brown
(b) Address 1045 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location _____

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 11 1945 (Date filed by registrar) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1945, to Aug 8. 1945, and that I last saw him alive on Aug. 8 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Diarrhea + dehydration	6 days
Due to Mild malaria	1 day
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Melvin A. Johnson M. D.
Address University Hospital Date signed 8-9-45

VS 150

X

G31469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G31469 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) L.O.C.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 E. Pratt Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Lutitia Kilgo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Oscar M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4 1903

8. AGE: Years	Months	Days	If less than one day
42	0	9	hr. min.

9. Birthplace Fulton Co. Georgia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name James P. Morgan
13. Birthplace ALA.

MOTHER 14. Maiden Name Lillian Benson
15. Birthplace ALA.

16 (a) Informant HARRY C. POOLE
(b) Address 184 PRYOR ST. ATLANTA GA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory ATLANTA
Location ATLANTA GA.

18 (a) Funeral director William Cook Inc.
(b) Address 121 St. Paul Street

19 AUG 11 1945 (Date rec'd by Registrar) Hunter Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 45 at 11:08 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver.

Due to

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed August 11, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G31470

JO #95249

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 Frederick Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Burke or Anna Burke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Imonler or Immler
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Klein
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Avenue

AUG 11 1945 (Date received by Registrar) (b) Huntingtown Wilkinson, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1945, to Aug. 9, 1945, and that I last saw her alive on Aug. 9, 1945.

	Duration
Immediate cause of death: Cerebral Embolus	?
Due to: Arteriosclerotic Heart disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 8-9-45

VS 150

631471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 631471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 W. Saratoga Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dean Cheston Harbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-2959

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theresa M. Harbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1882

8. AGE: Years	Months	Days	If less than one day
63 64	1	20	hr. min.

9. Birthplace Altoona Pa (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business A. D. T.

FATHER
12. Name Jacob Harbaugh
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Viola R. Eyler
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Theresa M. Harbaugh
(b) Address 411 W. Saratoga Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

19 (a) (b) Registrar
AUG 11 1945
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Aug 10 1945.
and that I last saw h[illegible] alive on Aug 8 1945.

Immediate cause of death	Duration
acute cardiac dilatation	3 hrs.
Due to hypertension, cardiac enlargement and chr nephritis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. S. Heyward M. D.
Address 115 E Eager St, Balto Date signed 8/11-45

X

G31472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 M

G31472 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 170 8 N Bethel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 170 8 N Bethel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Robert Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1878

8. AGE: Years	Months	Days	If less than one day
66	11	4	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Reuschling
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Dennis
15. Birthplace Md

16 (a) Informant Robert Shipley
(b) Address 170 8 N Bethel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13th 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Leo G. Brooks
(b) Address 1701-03 N Patterson Park Ave

19 (a) (Signature of registrar) (b) Date received (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th 1945, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to 8/9 1945, and that I last saw her alive on 8/9 1945.

Immediate cause of death Carcinoma - G. I. tract

Duration 3-4 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 206 E. Preston Date signed 8/10/45

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35612S G31473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55

G31473 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town 1421 Fremont Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Garland Mears

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	Married

6 (b) Name of husband or wife Josephine Mears
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 4 - 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation farming
11. Industry or business

FATHER
12. Name Andrew Mears
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Bread SMEAD
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/45 (month) (day) (year)
(c) Cemetery or crematory Buntow Cemetery
Location Buntow, Va.

18 (a) Funeral director Charles H Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) AUG 12 1945 (Date rec'd by registrar) (b) Registrar

Hunting for Williamsport

MEDICAL CERTIFICATION

35

20. DATE OF DEATH August 10 1945 at 10 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1945 to 8-10 1945 and that I last saw him alive on 8-10 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 23 July 1945

Major findings of operation: Carcinoma (Squamous) of Rt. Antrum

of autopsy:

PHYSICIAN Underline the cause to which death should be changed statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John William Hillmann
Address Johns Hopkins Hospital Date signed 10 Aug 45 M. D.

VS 150

X

G31474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31474 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Andrews.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Leopard
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-31

8. AGE: Years	Months	Days	If less than one day
14 13	-	12 2	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Arthur Leopard
FATHER 13. Birthplace ?

MOTHER 14. Maiden Name Pauline Robbins
MOTHER 15. Birthplace Md

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cambridge Md.
Location

18 (a) Funeral director Wm Cook Jnr
(b) Address 121 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.
AUG 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945 at 5-55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Aug 11 1945, and that I last saw h[illegible] alive on Aug 11 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Chronic Nephritis	8 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harriet G. Guild M. D.
Address Johns Hopkins Hospital Date signed 8/11/45

X

G31475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G31475 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 917
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1893

8. AGE: Years	Months	Days	If less than one day
52	7	1	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Grocer Business

FATHER
12. Name Isaac Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Reba Miller
15. Birthplace

16 (a) Informant Samuel S Miller
(b) Address 2549 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

AUG 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 1:07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to August 11 1945, and that I last saw him alive on August 11 1945.

	Duration
Immediate cause of death Peritonitis	48 hrs.
Due to Acute pancreatitis	48 hrs.
Due to Stone in common duct with common duct obstruction.	11 days
Other Conditions Fat necrosis	48 hrs.

(Include pregnancy within 3 months of death)

Date of operation July 31, 1945

Major findings of operation: Lungs distended stomach & intestines distended gallbladder

of autopsy: Peritonitis, pancreatitis, gall-stone common duct stone, fat necrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Chernin M. D.
Address Sinai Hospital Date signed 8/11/45

X

Koehne ✓ G31476

G31476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4621 Arabia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Koehne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business State Theatre

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. John Dunkee
(b) Address 4621 Arabia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran Cemetery
Location Golden Ring Road Balto. Md.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) Date received by registrar 8-12-1945 (b) Registrar Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945; at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945, to Aug. 9 1945, and that I last saw him alive on Aug 9 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	
Due to	
Other Conditions Tuberculosis; Pneumonia; Generalized Jaundice	

(Include pregnancy within 3 months of death)

Date of operation August 1, 1945
Major findings of operation: Annular Ca. Jaundice color
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Meyer M. D.
Address Mercy Hospital Date signed 8-10-45

X

G31477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G31477 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 E. Hill St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Hill St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John I. Cosgrove

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Florence Cosgrove

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1884

8. AGE: Years 63 | Months 2 | Days 21 | If less than one day hr. min. 25

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Patrick Cosgrove
13. Birthplace Ireland

MOTHER 14. Maiden Name Delia Callahan
15. Birthplace Ireland

16 (a) Informant Michael P. Cosgrove
(b) Address 12 E. Hill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

21945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14/45 19__, to 8/9/45 19__; and that I last saw h__ alive on Aug 9 19 45

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions June 14/45 Operation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Liver, Gall Bladder

of autopsy: Stomach etc

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Hammer M. D.
Address 11 E Chase St Date signed 8/10/45

G31478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

587 Registered No. G31478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) ~~Street address~~ University Hosp.
(c) Hospital or institution: 9 -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Pinkney (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country Poland

3 (a) **FULL NAME** Ida Gertman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Paul Gertman
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 15 1887

8. AGE: Years 58 | Months 4 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation house wife

11. Industry or business

FATHER 12. Name Samuel Cohen
13. Birthplace Poland

MOTHER 14. Maiden Name ~~Sarah~~ MOLLIE -
15. Birthplace Poland

16 (a) Informant Samuel Gertman (Son)
(b) Address 317 Landry Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Essex Md

18 (a) Funeral director Jack Levine Inc
(b) Address 1739 E. Balto. St

19 (a) 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1945 at 9.45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/4 1945 to 8/10 1945
and that I last saw her alive on 8/10 1945

Immediate cause of death Cerebral anoxia due to cardiac failure — Duration 6 da.

Due to rheumatic carditis — 46 yrs

Due to ____

Other Conditions Auricular fibrillation — 20 yrs

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature John P. Doenges M.D.
Address University Hosp. Date signed 8/11/45

Doenges

VS 150

Order 4 G31479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31479 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 S. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gussie Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis Weiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name M. Richstein
13. Birthplace Russia

MOTHER
14. Maiden Name ? ?
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St, Baltimore, Md

12 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 11 1945, at 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 11 1945, to Aug - 11 1945, and that I last saw h[illegible] alive on Aug - 11 1945.

Immediate cause of death Anterior type coronary infarction — Duration

Due to Coronary sclerosis & Hypertension cardiovascular disease

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Graham Edmunds MD
Address Johns Hopkins Hosp Date signed 8/11/45

For Dr. Jos. Sherman — Howard J. Worthington, M.D.

G31480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 S Charles
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 S. Charles
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza J. Tillery

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John A. Tillery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1844

8. AGE: Years 100 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Bladen Dulaney
13. Birthplace Balto Md

MOTHER
14. Maiden Name Elizabeth Emrich
15. Birthplace Balto Md

16 (a) Informant Mrs Hannah Conn
(b) Address 5003 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto

18 (a) Funeral director A. Edward Evans
(b) Address 1400 S Charles St

19 (a) (Patient's or registrar) (b) Huntington for Williams, M.D.

AUG 12 1945

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1945 to Aug. 11 1945 and that I last saw h[illegible] alive on Aug 10 1945.

	Duration
Immediate cause of death Broncho Pneumonia	2 d.
Due to Arterio Sclerosis	7 d.
Due to Chronic Interstitial Nephritis	7 d.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. A. Stevens M. D.
Address 2818 Hartford Rd Date signed 8-11-45

G31481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G31481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1631 N. Payson St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1631 N. Payson St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs Anastasia Knox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Geo Knox

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JLY 27, 1868

8. AGE: Years 77 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Md (Town, county, and State)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Alex Adelsberger

13. Birthplace Md

MOTHER

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Mrs J. B. Satterfield

(b) Address 1621 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 16 45 (month) (day) (year)

(c) Cemetery or crematory St. Louis

Location Tanneytown Md

18 (a) Funeral director C. O. Fuss & Son

(b) Address Taneytown, Md.

19 AUG 16 1945 (Date received by registrar) (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12/45, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 19, 1935 to Aug 12, 45, and that I last saw h[illegible] alive on Aug 11 19 45

Immediate cause of death Diabetes Mellitus — Duration 15 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George A Knupp

Address 3030 Edmondson Date signed 8/12/45 M.D.

VS 150

G31482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Greenmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berdetta Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/[illegible]

8. AGE: Years | Months: 4½ | Days: 13 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Celyles Thompson
13. Birthplace: Bald. Md.

MOTHER
14. Maiden Name: Myrtle Watkins
15. Birthplace: Baltimore Md.

16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof: 8-13-45 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary Cemetery
Location: Baltimore Md.

18 (a) Funeral director: Mayfield & Gadd
(b) Address: 210 W Fallsway

19 AUG 13 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1945, to Aug 11 1945, and that I last saw her alive on Aug 11 1945.

Immediate cause of death: Shock + dehydration

Due to: Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Blair Everett Batson M. D.
Assistant Resident
Address: Johns Hopkins Hospital Date signed 8/12/45

VS 189

631483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. 631483

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Av.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Battotety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4807 Gwynn Oak Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Franklin Sinton

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife (1st wife): Alice V. Sinton
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct-10-1866

8. AGE: Years 78 | Months 9 | Days 29 | If less than one day: hr. min.

9. Birthplace Richmond-Va.
(Town, county, and state)

10. Usual Occupation accountant

11. Industry or business Lord Balto. Hotel.

FATHER
12. Name George F. Sinton
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Bella Gray
15. Birthplace Richmond Va.

16 (a) Informant Mr. Wilbury H. Sinton (Son)
(b) Address 4804 Gwynn Oak Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-13-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville-Md.

18 (a) Funeral director Stewart Mgmt Co.
(b) Address 628 W Saratoga St

19 (a) AUG 13 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9. 1945 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11. 1945 to Aug. 9. 1945, and that I last saw h[illegible] alive on Aug. 9. 1945.

Immediate cause of death: Cardiac Dilatation acute
Due to: Chronic Myocarditis
Due to: chronic Bronchitis

Duration: many years

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunter G. Blake M. D.
Address Med. Arts Bldg. Date signed

VS 180

G31484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G31484

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Lancaster St.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME Stanislaw Stanley Jachim

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Separated

6 (b) Name of husband or wife ? ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1892

8. AGE: Years	Months	Days	If less than one day
53	4	15	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Frank Jachim
13. Birthplace Poland
14. Maiden Name Anna ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14/45 (month, day, year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave
(b) Registrar Huntington Williams M.D.
AUG 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10th, 1945, at 5:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6, 1945 to Aug. 10th 1945, and that I last saw him alive on Aug. 10th 1945.

Immediate cause of death	Duration
Cerebral Embolism	?
Due to Subacute Bacterial Endocarditis	?
Due to Aortic Insufficiency	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. A. Jernigan
Address Baltimore City Hosp. Date signed 8-10-45 M. D.

VS 150

G31485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 Oswego Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2505 Oswego
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state or country)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Kutta
15. Birthplace Russia

16 (a) Informant Ben Cooper
(b) Address 2505 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Peirce Inc
(b) Address 1731 E. Balto. St.

19 (a) AUG 13 1945 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/45, at 8.35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D.
Medical Examiner.
Date signed 8/12/45.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 631486

1. PLACE OF DEATH:
(a) ~~Baltimore City, Maryland~~
(b) Street address Baltimore Maryland
(c) Hospital or institution: Union Memorial Hospital 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 E. 28th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Albert

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mamie Albert
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Ferry ticket agent
11. Industry or business City of Baltimore

FATHER
12. Name John Albert
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Margaret Shammel
15. Birthplace Baltimore, Maryland

16 (a) Informant Margaret Puhl-daughter
(b) Address 1817 E 28th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by local registrar) AUG 13 1945 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1945, at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 9/6
(a) Date of injury 8-4-45 at 4 P. M.
(b) Where did injury occur 1818 E. 28th Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fall down a flight of steps

23. Signature Howard Mahon M.D. Medical Examiner.
Date signed August 10, 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31487 Registered No. 1042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Leroy Dyson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6-1945

8. AGE: Years	Months	Days	If less than one day
	6	9 5	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Randall
13. Birthplace Md

MOTHER
14. Maiden Name Mildred Dyson
15. Birthplace Md

16 (a) Informant Mildred Dyson
(b) Address 930 N. Stricker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Sam'l W. Chase & Son
(b) Address 688 N. Gilmor St.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

AUG 13 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11-1945, at 11:35 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uppr Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature Howard J. Wilkerson M.D.
Medical Examiner.
Date signed 8-11-45

X

631488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. 631488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lake Drive Apts. 8 B.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lake Drive Apts. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE STRAUS MICHAEL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband or wife Harry C. Michael.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1889.

8. AGE:	Years	Months	Days	If less than one day
	56		10	hr. min.

9. Birthplace Erie, Pa. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Alexander L. Straus,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara M. Ostheimer,
15. Birthplace Erie, Pa.

16 (a) Informant Mr. Harry C. Michael,
(b) Address Lake Drive Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.13.45. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Emanuel Sonneborn & Sons
(b) Address 1902 Eutaw Place.

AUG 13 1945 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Aug. 11th. 1945 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to Aug. 11, 1945. and that I last saw her alive on 8/11/ 1945.

Immediate cause of death Carcinoma of Stomach — Duration about 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore N. Monson M. D.
Address 11 E. Chase St. Date signed 8/11/45

VS 150

X

G31489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 D

G31489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Brinkley

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 18 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	-	22		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Contractor Con Co.
11. Industry or business

FATHER
12. Name Isiah Brinkley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Harriet
15. Birthplace Baltimore Md

16 (a) Informant Marcella Smith
(b) Address 133 N. Belnord Ave.

17 (a) Burial, cremation, or removal: Burial (b) Date thereof (month) 8 (day) 13 (year) 45
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director M.W.E. Diggs & Sons
(b) Address 1619 Lord Baltimore Dr.

19 (Date rec'd by registrar) AUG 13 1945 Huntington Williams Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 45 at 6.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to Aug. 10 1945
and that I last saw him alive on Aug. 9 1945

Immediate cause of death	Duration
Acute Myocard. Insuff.	2 days
Due to Chr. Myocarditis & Arteriosclerosis	?
Due to	
Other Conditions Chr. Bronchitis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] D.
Address 200 E. Eager St. Date signed 8/11/45

VS 150

G31490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 ✓

Registered No. G31490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 567 Preastman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 567 Preastman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Curtis Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1871

8. AGE: Years 74 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, County, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Price
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Henrietta Price
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Dorothy Stewart
(b) Address 567 Preastman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md

18 (a) Funeral director Mrs. George H. Stoddard
(b) Address 1601 Druid Hill Ave

19 (a) AUG 13 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1945 at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945, to Aug 10 1945, and that I last saw h alive on Aug 10 1945

Immediate cause of death	Duration
Cerebral Apoplexy.	
Due to Hypertension.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Jos. P. Julian Jr. M. D.
Address 511 N. Schroeder St Date signed Aug 13

VS 150

G31491

HEP #95250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 60-5 - 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lemuel Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Etheldra

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1885

8. AGE: Years	Months	Days	If less than one day
60	5	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ? ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Gibbons Mem. Pk. Location Baltimore, Md

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Huntington Williams, M.D.

AUG 13 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1945 to Aug. 9, 1945, and that I last saw h im alive on Aug. 9, 1945

Immediate cause of death	Duration
Cardiac failure, (extreme congestion)	
Due to hypertensive cardio-vascular disease	
Due to	
Other Conditions Acute arteriolar-nephrosclerosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 8/10/45

G31492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31492

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Ray Martin

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-7602

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or ~~divorced~~
Male	White	Married

6 (b) Name of ~~husband~~ or wife Edna M. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1841

8. AGE: Years	Months	Days	If less than one day
53	8	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business F. A. Davis & Sons

FATHER
12. Name Frank. Martin
13. Birthplace Md

MOTHER
14. Maiden Name Clara A. McCambridge
15. Birthplace Md

16 (a) Informant Mrs Edna M. Martin
(b) Address 4211 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williamsport Md

AUG 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 2.32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 10 1945 to August 11 1945, and that I last saw ~~him~~ alive on August 11 1945.

Immediate cause of death Coronary Thrombosis — Duration 24 hrs.

Due to Arteriosclerotic cardiovascular disease — 3 years.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roy D. Bigham, Jr. M. D.
Address R.F.D. Fuller Ridge Rd Freedom Md Date signed 8/17/45

G31493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G31493

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1567 Ellwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1567 Ellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Pugh Nawel

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Warren G. Nawel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5-1882

8. AGE: Years	Months	Days	If less than one day
63	7	7	hr. min.

9. Birthplace Bowling Green Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name	Wm H Pugh
FATHER 13. Birthplace	Va
MOTHER 14. Maiden Name	Christina Eubanks
MOTHER 15. Birthplace	Va

16 (a) Informant Theron G. Nawel
(b) Address 1033 N. Milton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15-1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Md
18 (a) Funeral director Bertram Lore
(b) Address 3324 N. Charles St.
19 (Date received by registrar) AUG 13 1945 (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Aug 12 1945, and that I last saw her alive on Aug 12 1945.

Immediate cause of death
Arteriosclerosis
Hypertension Vascular disease

Duration
2 yrs
2 yrs
1 yr

Due to

Due to

Other Conditions Diabetes Mellitus
Uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jesse T. Cavanaugh MD
Address 3328 W. Belvedere Ave Date signed Aug 13 1945

VS 3

93D

G31494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G31494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith G. Mitchell

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-25-18
8. AGE: Years 26 | Months 8 | Days 15 | If less than one day: hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME
FATHER 12. Name George Lucas
13. Birthplace Va.
MOTHER 14. Maiden Name Rosamae Rogers
15. Birthplace Va
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 14/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.
18 (a) Funeral director Lilly & Gaither
(b) Address 403 S. BOLEY ST.
19 (a) AUG 13 1945 (Date rec'd by registrar) Registrar for Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 2.35 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to Aug 11 1945 and that I last saw h[illegible] alive on Aug 11 1945.

Immediate cause of death	Duration
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Graham A. Young MD
Address Johns Hopkins Hospital Date signed 8/12/45

VS 350

G31495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 N. Belnord Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Belnord Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William A. Webb

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 263-10-4605

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret L. Webb
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 28 1895

8. AGE: Years	Months	Days	If less than one day: hr.	min.
50.	-	22		

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Beth Steel Co

FATHER
12. Name Milladay Webb
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ida M. Roberts
15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret L. Webb
(b) Address 805 N. Belnord Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location 2220 Eastern Ave

18 (a) Funeral director John F. Bowman & Son
(b) Address 901-03 Hollins St

AUG 13 1945
(Date rec'd by registrar)

(b) Thurlington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th 1945, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1945, to 8-10 1945 and that I last saw h[illegible] alive on 8-10 1945

Immediate cause of death	Duration
Coronary Sclerosis	
Due to Angina Pectoris	months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Wm Dewey M. D.
Address 790 E. Mount St Date signed 8/13/45
By request Dr Dewey
M. E.

G31496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G31496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospt
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Lyndhurst St —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine M. Tignall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White. | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 12 1945

8. AGE: Years | Months | Days | If less than one day: — hr. 30 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Earl S. Tignall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Helen E. Nolan
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Earl S. Tignall
(b) Address 914 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd

18 (a) Funeral director John J. Conway & Son
(b) Address 901-03 Hollins St

19 (a) AUG 13 1945 Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1945; at 11 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1945 to 8/12 1945 and that I last saw her alive on 8/12 1945

Immediate cause of death: Congenital atelectasis — Duration: 1/2 hr.
Due to: Prematurity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Schultz Jr. M. D.
Address Bon Secours Hospt Date signed 8/13/45

VS 8

G31497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G31497

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3225 Phila Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 3225 Phila Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine W Buhmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2 1866

8. AGE: Years 78 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Oscar Buhmer
(b) Address 3225 Phila Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 Date received by registrar AUG 13 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-11-1945 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to Aug-11-1945 and that I last saw her alive on Aug 11 1945.

Immediate cause of death Acute Cardiac Dilatation — Duration 2 hr

Due to Myocardial Insufficiency — 2 yrs.

Due to Chr Interstitial Nephritis — General Anasarca

Other Conditions Ascites

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W. G. Geyer M.D.

Address 1506 N. Melton Ave Date signed 8/11/45

VS 150

631498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

Registered No. G31498

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4213 Shamrock Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Mogavero

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 3 min.

9. Birthplace Hospital for the Women of Md. Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Marion Joseph Mogavero
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Gozier Kekeleus
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs. Marion J. Mogavero
(b) Address 4213 Shamrock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate Md

18 (a) Funeral director Ulloth Funeral Home
(b) Address 2008 Eutaw St.

19 (Date received by local registrar) AUG 13 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h.c.r. alive on Aug 12 19 45.

Immediate cause of death: Respiratory failure.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Jordan M. D.
Address Hospital for the Women of Md. Date signed Aug 13, 1945

X

631499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

631499 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1016 Gradenhall Street

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2D

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1016 Gradenhall (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ella M Tobette J White

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	married

6 (b) Name of husband or wife William H White

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 15 1883

8. AGE: Years	Months	Days	If less than one day
62	—	26	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James Harris

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Annie Jackson

15. Birthplace Baltimore Md

16 (a) Informant William H White

(b) Address 1016 Gradenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13 45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md

18 (a) Funeral director Isaac L Brannon

(b) Address 1000 Montgomery Street

19 (a) AUG 13 1945 Interment for Williamsville

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 10 1945, and that I last saw h alive on 8/9 1945.

Immediate cause of death Coronary Embolism

Due to Myocarditis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David Frumkin M. D.

Address 1000 Lee Date signed 8/11/45

920

G31500

JO #94816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G31500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Stirling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1920

8. AGE: Years	Months	Days	If less than one day
25	-2-	28	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Ed Elliott
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha ?
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director A. Halstead
(b) Address 918-Druid Hill Ave

19 AUG 13 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 9, 1945, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22, 1945 to Aug. 9, 1945, and that I last saw her alive on Aug. 9, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	>
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 9/11/45

VS 150

G31501

CWK-94868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1373

Registered No. G31501

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 9-44

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 43- 1- 19

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore-Md (If outside city or town limits, write RURAL and give town)

(d) Street No. 2731 Greenmount Avenue (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No) If yes, name country .....

3 (a) FULL NAME Marie Mitchell

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Anthony Mitchell (D)

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 11-1902

8. AGE: Years	Months	Days	If less than one day
43	1	19	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name Moss Harrison

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Martin

15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14, 1945 (month) (day) (year)

(c) Cemetery or crematory Lehwalt's

Location Old Dorsey Rd

18 (a) Funeral director Wendel Riggs

(b) Address 315 S. Highland Ave Huntington Park, Md

19 (a) Date received AUG 13 1945 (b) Registrar .....

VS 350

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 10 1945, at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945, to August 10 45, and that I last saw her alive on Aug. 10 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Robert B. Copeland Jr. M. D.

Address Balto. City Hosp. Date signed 8/11/45

G31502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G31502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hutchins & Eaton Sts.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nils Broman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife June

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2 1906

8. AGE: Years	Months	Days	If less than one day
38	10	10	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation Steward
11. Industry or business Restaurant

FATHER
12. Name Christian
13. Birthplace Sweden

MOTHER
14. Maiden Name Annette
15. Birthplace Sweden

16 (a) Informant (Wife) June Broman
(b) Address 1619 Bolton St

17 (a) Buried (Buried, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director Wm. Poole Sons
(b) Address 1217 E. Baltimore St. Huntington Williams, Mgr.

19 AUG 13 1945 (b) Registrar
(Date rec'd by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1945 to 8-12 1945 and that I last saw him alive on 8-11 1945

Immediate cause of death Uremia — Duration

Due to Nephro Sclerosis

Due to Malignant Hypertension

Other Conditions Pericarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Cottrell Jr. M.D.
Address 25 Agnes Lane Date signed 8/13/45

VS 150

G31503 Baltimore ✓ G31503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Burgundy St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel ~~Gardner~~ Daley Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard Gardner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1894

8. AGE: Years 51 | Months 3 4 | Days 20 | If less than one day ? hr. ? min.

9. Birthplace Hanover, Md. (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name Sam Clark
13. Birthplace Hanover, Md.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Hanover, Md.

16 (a) Informant Nettie Bragon
(b) Address 503 Burgundy St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 14 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemtry
Location Baltimore

18 (a) Funeral director Hatton Bishop Co
(b) Address 139 W. Hamburg St.

19 (a) AUG 13 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1945, at 2 36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1945, to Aug 10 1945, and that I last saw h[illegible] alive on Aug 10 1945

Immediate cause of death	Duration
Cardiac Rheumatic Failure	
Due to Partial Cardiac Cerebral Edema	
Due to	
Other Conditions Meningitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Harey M. D.
Address Univ. Hosp. Date signed 8-10-45

VS 150

J. B. Harey

G31504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G31504
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy O'Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
-	8 -	-	3 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Hugh Oconnor
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice Cannon
15. Birthplace Baltimore

16 (a) Informant Miss Bianco
(b) Address 1015 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Pulaski Highway

18 (a) Funeral director J. J. Doyle & Son
(b) Address 1311 Light St

19 (a) AUG 13 1945 (Date rec'd by registrar) (b) Huntington, Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1945 at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1945 to 8/12 1945 and that I last saw her alive on 8/12 1945

Immediate cause of death Atelectasis & incomplete development of body organs — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Theriot Jr. M. D.
Address Bon Secours Hosp Date signed 8/13/45

VS 8

G31505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a Registered No. G31505

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Will Norris

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-9258

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Manerva

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-22-1882

8. AGE: Years 63 | Months 3 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Daniel Norris
13. Birthplace S.C.

MOTHER 14. Maiden Name Amanda ?
15. Birthplace S.C.

16 (a) Informant Manerva Norris
(b) Address 1512 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 15 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1945 to Aug 12 1945
and that I last saw h alive on August 1 1945

Immediate cause of death Acute Regurgetation

Duration 2 Mo 1 Day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Whitehead M.D.
Address 1525 Park Date signed 8/13/45

G31506 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G31506

CERTIFICATE OF DEATH

1312

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 S. Curley St., 1 Ward)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME George W Zaleski

(a) Residence: No. 1027 S. Curley St., Ward.
(Usual place of abode) Md (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Casimir

6. DATE OF BIRTH (month, day, year) 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Michael Nowak

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT Casmir Zaleski
(Address) 1027 S Curley St.

18. (BURIAL), CREMATION, OR REMOVAL
Place St Stanislaus Date 8/14 19 45

19. UNDERTAKER John J Dyda
(Address) 2829 Hudson St

FILED AUG 13 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 11, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1945 to Aug 11, 1945

I last saw HE alive on Aug 9, 1945. Death is said to have occurred on the date stated above, at 7 45 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic glomerulo-Nephritis Uremia	June 19 45
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) Theodore L. Grayson M. D.
(Address) 618 Medical Arts Bldg

X

G31507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

Registered No. G31507

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene + Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balti
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 876 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delores Buell

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1945

8. AGE: Years 7 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Bull
13. Birthplace Darlington S.C.

MOTHER
14. Maiden Name Pearl Pringle
15. Birthplace Sumter S.C.

16 (a) Informant Mrs Pearl P. Bull.
(b) Address 876 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 13 1945 (Date received by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1945 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1945 to 8-11 1945 and that I last saw her alive on 8-11 1945

Immediate cause of death acidosis

Due to vomiting + diarrhea

Due to severe dehydration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Dorcas Clark

Address University Hosp Date signed 8-11-45 M. D.

G31508
AB-94626

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

Registered No. G31508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-2days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William August

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4603

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3- 1880

8. AGE: Years	Months	Days	If less than one day
64	8	8	hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John August
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary Jones Dun
15. Birthplace Delaware

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wm. E. Milby Inc
(b) Address 442 E. Oliver St
(b) Huntington Williams Mgr.

AUG 13 1945
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11- 1945 at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9- 1945 to 8-11 1945 and that I last saw h im alive on 8-11- 1945

Immediate cause of death	Duration
Cachexia	3 wks
Due to Carcinemna at	
Colon & complete obstruction	6 mo.
Due to	
Other Conditions G. Prostatic hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation 7-11-45 & 8-7-45
Major findings of operations same as above
of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto City Hosp Date signed 8-11-45

VS 150

G31509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E ✓

Registered No. G31509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 W Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 W. Fayette St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lauras Leikus (Laikus)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1790

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith,

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Annie Leikus
(b) Address 730 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kaznoker
(b) Address 602 Park Ave

19 (Registrar's signature) AUG 13 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945, to August 7 1945, and that I last saw him alive on August 1 1945.

Immediate cause of death Confluent Failure — Duration 2 days

Due to Squamous Cell Carcinoma of Neck — 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. O'Donnell M. D.
Address 7301 York Rd Date signed 8/9/45

X

G31510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31510

Registered No. 164a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address UNION MEMORIAL HOSP
(c) Hospital or institution: UNION MEMORIAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 7 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town NEW YORK CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E 78TH STREET (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY GERTRUDE PUSINELLI

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: * * *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) JUNE 8 - 1886

8. AGE: Years 59 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace ORANGE NEW JERSEY (Town, county, and state)

10. Usual Occupation SECRETARY-TO

11. Industry or business LAWYER

FATHER
12. Name JOHN F. HART
13. Birthplace NEW JERSEY

MOTHER
14. Maiden Name MARY E. O'DOWD
15. Birthplace IRELAND

16 (a) Informant O. SCOTT MILLER
(b) Address 313 WOODBOURNE AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-14-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location ARLINGTON, NEW JERSEY

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 118 W MT ROYAL AVE

19 (d) 1945 Huntington Williams, M.D. Registrar
(Date filed by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1945, at 10 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation + Asphyxiation

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/12/45 at 7-8 A.M. P.M.
(b) Where did injury occur? 313 Woodbourne Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging by proper

23. Signature Joseph L. Sherman M.D. Medical Examiner.
Date signed 8/12/45

G31511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. G31511

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 Oakley Beach Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Denver Chester Day

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	234-03-5218	Male	White	Married

6 (b) Name of husband or wife Leota Maxine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1914

8. AGE: Years	Months	Days	If less than one day
30	8	3	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name William W. Day
13. Birthplace W. Va.

MOTHER
14. Maiden Name Anita Meek
15. Birthplace W. Va.

16 (a) Informant Mrs. Leota Maxine Day
(b) Address 850 Oakley Beach Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/13/45 (month) (day) (year)
(c) Cemetery or crematory Parkersburg W. Va.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address 1001 North Pennsylvania Aves.

19 (a) Harrington Williamson
(Date rec'd by registrar) (Registrar)

AUG 13 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1945, at 6:50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Internal hemorrhage, due to laceration of lung.

Due to

Other Conditions Abrasions, bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-45 at 1:55 P. M.
(b) Where did injury occur? 850 Oakley Beach Dr. Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Motorcycle Auto collision.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed August 12, 1945.

G31512

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

G31512

830 Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town: Balto. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
Elmhurst Nursing Home-1708 Eutaw. Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Catonsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 625 Coleraine, Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY E. AIREY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Geo. Airey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1/24/52

8. AGE:	Years	Months	Days	If less than one day
	93	6	19	..... hrs. ..... min.

9. Birthplace: Catonsville, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: John Green
13. Birthplace: Md.

MOTHER
14. Maiden name: Matilda Marsh
15. Birthplace: Md.

16. Informant: Mrs. Addie Triplett
Address: Catonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/45 (month) (day) (year)

Cemetery or crematory: Wards Comly

Location: Liberty Rd.

18. Funeral director: John C. Mitchell Funeral Home
Address: 1900 Eutaw Place

19. Filed 8 19 45 (Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/12 45 19 at 5.15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-9- 19 45, to 8-12- 19 45 and that I last saw h[illegible] alive on 8-12-45 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Adv. Atherosclerosis	
Due to: Adv. age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis J. Jacob M. D.
M. D. or other

Address: 1700 Eutaw Pl. Date signed: 8-13-45

G31513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G31513

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie D. Coppedge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John E. Coppedge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, ~~1864~~ 1864

8. AGE: Years	Months	Days	If less than one day
80 ~~87~~	9	15	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew Stiff
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Barrick
15. Birthplace Virginia

16 (a) Informant Mrs. Nellie E. Frederick
(b) Address 1908 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director E. W. Pennington
(b) Address 4510 Liberty Heights Ave.

AUG 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945 at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1944 to Aug 12 1945, and that I last saw h~~er~~ alive on Aug 11 1945.

Immediate cause of death	Duration
Carcinoma of Sigmoid	18 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer A. Todd M. D.
Address 735 N. Eutaw St. Date signed 8/12/45

VS 8

(OVER)

631514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

631514 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Calvert St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4011 Perkio Rd (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Adriani

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/45

8. AGE: Years	Months	Days	If less than one day
0	0	0	4 hr. 15 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Paul J. Adriani

13. Birthplace Georgia

MOTHER 14. Maiden Name Betty Mae Bush

15. Birthplace Georgia

16 (a) Informant Mercy Hosp.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director C. Vernon Lenzman

(b) Address 4611 Pk. Hgts

AUG 14 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:45 P.M. 8/12 1945 to 11:00 P.M. 8/12 1945, and that I last saw him alive on 8/12 1945

Immediate cause of death	Duration
Tracheo-Bronchial obstruction	4 hrs
Due to Atelectasis and Prematurity (2 wks.)	
Due to	
Other Conditions True knot of umbilical cord	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph E. Leal M. D.

Address Mercy Hospital Date signed 8/13/45

VS 150

G31515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G31515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2134 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilyhman Kahl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Late Emma A Bosley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1858

8. AGE: Years 66 Months 11 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER | FATHER

12. Name —— Kahl

13. Birthplace Germany

14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Mrs Mary E. Gorsuch

(b) Address 2134 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Wittstein

(b) Address 4401 Edmondson Ave

19 (a) AUG 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945 at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1943, to Aug 11 1945, and that I last saw him alive on Aug 11 1945.

	Duration
Immediate cause of death Diabetes Mellitus	
Due to Arteriosclerotic Cardiovascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl H. Fosbury M.D.

Address 326 W Lombard St Date signed 8/13/45

VS 150

X

G31516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Brooklyn Pk.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 8th Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pietro Ferrarini

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 220-05-1058

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Fernanda Ferrarini

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1881

8. AGE: Years	Months	Days	If less than one day
64	1	6	hr. min.

9. Birthplace Massa Carrara Italy
(Town, county, and state)

10. Usual Occupation Crane push

11. Industry or business Fairfield Ship Yard B.S.Co.

FATHER
12. Name Beniamino Ferrarini
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppa Puntelli
15. Birthplace Italy

16 (a) Informant Fernanda Ferrarini (Wife)
(b) Address 4 8th Ave Brooklyn Park Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel Co.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 AUG 14 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 19 45, at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock.
Traumatic amputation, leg
Fractured Pelvis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-45 at 9:30 P.M.
(b) Where did injury occur? Baltimore Iron Ship yds Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Injured by a crane.

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 8-13-45

VS 151

G31517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns
(c) Hospital or institution:
Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs 29 mins
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs 29 mins

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore 750 Charing Cross Rd
(c) City or town Baltimore-27
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lafayette & Johns
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country 750 Charing Cross Rd

3 (a) **FULL NAME** Baby Girl Wood

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/45

8. AGE: Years	Months	Days	If less than one day
			8 hrs 29 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Richard Eugene Wood
13. Birthplace Austin Minnesota

MOTHER
14. Maiden Name Jeanne Elizabeth Harris
15. Birthplace Chicago Ill.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 14 1945 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1945; at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1945; to 8/4 1945; and that I last saw her alive on 8/4 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	8 hrs 29 min
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Teofilo A. Rojas M.D. M. D.
Address Hospital for Women of Md. Date signed

VS 150

X 8/4/45

G31518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G31518

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Hospital for the Women of Maryland 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17hrs 2min

(e) Length of stay in Baltimore (yrs., mos., or days) 17hrs 2min

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1716 Johns Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl (A) Buckner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			17 hr. 2 min.

9. Birthplace Hospital for the Women of Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Anthony Wayne Buckner

13. Birthplace Philadelphia, Pa.

MOTHER

14. Maiden Name Angella Anna Holland

15. Birthplace Fairmount Pa

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director PUBLIC CEMETERY AUG 13 1945

(b) Address Commissioner of Health

19 (Date rec'd by registrar AUG 14 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945, at 1:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1945, to August 7 1945, and that I last saw he alive on August 7 1945.

	Duration
Immediate cause of death Pneumothorax	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature R. F. Jordan M. D.

Address Hospital for the Women of Md. Date signed Aug 7, 1945

31519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 48 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl (B) Buechner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1945

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Hospital for the Women of Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Anthony Wayne Buechner
13. Birthplace Philadelphia, Pennsylvania

MOTHER
14. Maiden Name Angella Anna Kalland
15. Birthplace Fairmount, Pennsylvania

16 (a) Informant Angella Kalland Buechner
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 14 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1945, to August 8 1945, and that I last saw h.e.r. alive on August 8 1945.

Immediate cause of death: Respiratory Failure — Duration

Due to: Prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. T. Jordan M. D.
Address Hospital for the Women of Md. Date signed 8-8-45

X

G31520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 112 S.Loudon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 112 S.Loudon Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Catherine Dowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William W.Dowell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1868

8. AGE: Years	Months	Days	If less than one day
77	1	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER: 12. Name Michael O'Connor

13. Birthplace Ireland

MOTHER: 14. Maiden Name Dorothy Adams

15. Birthplace Baltimore Md

16 (a) Informant O'Delia Cook

(b) Address 38 S.Morley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director Henry T. Chenowith

(b) Address 4204 Ridgewood Ave

AUG 14 1945 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943, to Aug 11 1945, and that I last saw her alive on Aug 11 1945.

Immediate cause of death.

Coronary Occlusion

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 Day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J McGolrick M. D.

Address 3321 Frederick Date signed 8-13-45

VS 150

G31521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 North Bentalow
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 3 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 North Bentalow
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX SIROTA

3 (b) If veteran, name war

3 (c) Social Security Account No. A 213-058698

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anna-

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Russia Poland
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph-
13. Birthplace Russia Poland

MOTHER
14. Maiden Name Baila-
15. Birthplace Russia Poland

16 (a) Informant Anna Sirota
(b) Address 2003 N. Bentalow St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-45 (month) (day) (year)
(c) Cemetery or crematory North Point Memorial Park
Location Hill Road

18 (a) Funeral director Jack Rems Inc
(b) Address 1439 E. Balto. St

AUG 14 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/45, 19..., at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 8/13/45

VS 151

...CT, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G31522

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Cornell Street
(c) Hospital or institution: CORNELL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimae
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Cornell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Tilghman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1897

8. AGE: Years 47 | Months 11 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Gracesville Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Coleman
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Josephine Robinson
15. Birthplace Eastern Shore Md

16 (a) Informant Anna Hymon Daughter
(b) Address 613 Cornell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1945 (month) (day) (year)
(c) Cemetery or crematory Bethel Cemetery
Location Kent County Md

18 (a) Funeral director Joseph A. Lusby
(b) Address 4090 W. Mulberry Baltimore

19 (a) AUG 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945 at 1250 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1945 to 8/13 1945 and that I last saw h[illegible] alive on 8/7/ 1945

Immediate cause of death — Duration

Carcinomatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. P. Howell M. D.

Address 601 N. Arrowhead Date signed 8/12/45

VS 8

G31523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G31523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland Sts
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore # 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 67 Lanvale Court, Apt. B
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Marie Werner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2. 1945

8. AGE: Years | Months | Days 5 4 | If less than one day ... hr. ... min.

9. Birthplace West Balto. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George William Werner
13. Birthplace Penna.

MOTHER 14. Maiden Name Pauline Marguerite Murray
15. Birthplace Penna.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 14 1945 Huntington Williams, M.D.
Filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945 at 10:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945, to 8/6 1945, and that I last saw her alive on 8/6 1945.

Immediate cause of death Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sub-dural hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar Hartman
Address 221 Eutaw St Date signed 8/7/45

VS 180

G31524 BALTAZAR HATTA ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G31524

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N. Madeira St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baltazar Hatta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Amelia Hatta
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec 9. 10 1889

8. AGE: Years	Months	Days	If less than one day
56		2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business Street Cleaning Dept

FATHER
12. Name Gartogal Hatta
13. Birthplace Bohemia

MOTHER
14. Maiden Name Barbara Studnicka
15. Birthplace Bohemia

16 (a) Informant Amelia Hatta
(b) Address 924 N. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Mack Enoch & Son
(b) Address 900 E. Chester St

19 (a) AUG 14 1945 Huntington Williams & Co

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1945 at 1:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1945, to 8-12 1945, and that I last saw him alive on 8/12 1945

Immediate cause of death	Duration
Acute cardiac failure (probable coronary thrombosis)	
Due to	
Due to	
Other Conditions Lymphatic leukemia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald E. Crane
Address Maryland General Hospital Date signed 8/14/45

VS 150

Gerald E. Crane

G31525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31525

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 602 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country B. W. I.

3 (a) FULL NAME Antone Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Elizabeth Peters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years Approx 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace B. W. I. (Town, county, and state)

10. Usual Occupation Carpenter (Unemployed)

11. Industry or business

FATHER 12. Name Unknown.

13. Birthplace

MOTHER 14. Maiden Name Unknown.

15. Birthplace

16 (a) Informant Bessie Lovett

(b) Address 236 Eagle Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert H. Young

(b) Address 804 N. Caroline St.

19 (a) AUG 14 1945 (Registrar's signature) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2- 1945 to 8-13- 1945, and that I last saw h alive on 8-13- 1945.

Immediate cause of death Cardiac - Renal disease — Duration Unknown

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Bengel M. D.
Address 611-N Caroline Date signed 8-14-45

VS 150

G31526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Southern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah, Daisy Trautmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Adam Trautmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1876

8. AGE: Years 69 | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Samuel Erwin

13. Birthplace Baltimore

MOTHER 14. Maiden Name Margaret Frost

15. Birthplace Md

16 (a) Informant Mrs Effie Reis

(b) Address 3526 Hickory Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Uelrich Funeral Home

(b) Address 1601 Orleans St

19 (a) AUG 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945, at 6 1/2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1945, to Aug 12 1945, and that I last saw h[illegible] alive on Aug 11 1945.

Immediate cause of death Cerebrovascular Hemorrhage Disease — Duration: [illegible]

Due to — Duration: [illegible]

Due to — Duration: [illegible]

Other Conditions — Duration: [illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Dennis M. D.

Address 4808 Harford Date signed 8/13/45

Ref. X

VS 150

631527 Seebach

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 631527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Seebach

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Seebach

6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Nov. 10, 1878

8. AGE: Years 66 | Months 9 | Days 3 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: U.S. Printing & Lithographing

FATHER
12. Name: Henry Seebach
13. Birthplace: Balto. Md

MOTHER
14. Maiden Name: Lina Eiser
15. Birthplace: Balto. Md

16 (a) Informant: Mary E. Seebach
(b) Address: 2812 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 16. 1945 (month) (day) (year)

(c) Cemetery or crematory: London Park
Location: City

18 (a) Funeral director: Mr. Mrs. John W. Teufel & Son
(b) Address: 891 W. Fayette St

19 (a) AUG 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 19 45, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Chronic Arteriosclerosis Generalized
Due to

Other Conditions Senility & Arteriosclerosis,
Chronic Nephritis. Fatty Liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed August 16, 1945.

VS 151

G31528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 N. Ellwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Ellwood Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Franklin Robinson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bessie J. Mach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1892

8. AGE: Years 53 yrs. | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Huntington, Ind.
(Town, county, and state)

10. Usual Occupation Pa. R. R.

11. Industry or business

FATHER
12. Name Elliott Robinson
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Bessie J. Robinson
(b) Address 617 N. Ellwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)

(c) Cemetery or crematory Oak Hill
Location Phila. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by registrar) (b) [illegible]

VS 1 AUG 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1945, at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1936 to 8/11 1945.
and that I last saw h[illegible] alive on 8/10 1945

Immediate cause of death: Coronary Thrombosis. — Duration: 1 day.
Due to
Due to: Arteriosclerotic Cardiovascular Renal Disease, — Duration: 5 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter P. Sikorsky M. D.
Address 2439 E. Eager St. Date signed 8/14/45

G31529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163a

G31529 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 W. Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo C. Horstman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1885

8. AGE: Years	Months	Days	If less than one day
59	10	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Colored

11. Industry or business

FATHER 12. Name Henry H.
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Genevieve Mentens
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Josephine Herpel
(b) Address 1909 McKean ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Martin Tapley & Sons
(b) Address 1827 N. North Ave.

19 AUG 14 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 11:40 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Phosphorus Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12:10 PM at 8-12-45 M.
(b) Where did injury occur? 1714 W. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? and
(d) Means of injury Ingestion of Rat Poison

23. Signature Howard J. Mc Gucis M.D.
Medical Examiner.
Date signed 8-13-45

G31530 G31530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2643 EDMONDSON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2643 EDMONDSON AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY KAHLER

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 717-07-7301

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 8 - 1872

8. AGE: Years 72 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation BRAKE INSP.

11. Industry or business PENN. RAIL ROAD

FATHER 12. Name JACOB KAHLER

13. Birthplace BALTIMORE

MOTHER 14. Maiden Name JOHANNAH HORPEL

15. Birthplace BALTIMORE

16 (a) Informant MRS. LULA A. RUHL

(b) Address 2643 EDMONDSON AVE.

17 (a) BURIAL (b) Date thereof 8-15-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory BALTIMORE
Location NORTH AVE.

18 (a) Funeral director GEO. LESTER WEBER

(b) Address 2503 EDMONDSON AVE

AUG 14 1945 (b) Huntington Woodstock, Md. Registrar
(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 8.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Aug 13 1945, and that I last saw him alive on August 11 1945.

Immediate cause of death Cerebral Embolism

Due to Generalized arterio-sclerosis with hypertension

Due to

Other Conditions arterio sclerotic type heart disease & hypertrophy

(Include pregnancy within 3 months of death)

Duration 1 week / several years

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.

Address 2501 Edmondson Ave Date signed Aug. 13. 45

G31531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G31531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Calvert St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dd.

(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County -

(c) City or town 6025 Harford Rd (If outside city or town limits, write RURAL and give town)

(d) Street No. Baltimore Md. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Theresa Roncari (Teresa Roncari)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or ~~wife~~ Satiro Roncari

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	1	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Cerruti

13. Birthplace Italy

MOTHER 14. Maiden Name Catherine Scaglia

15. Birthplace Italy

16 (a) Informant Satiro Roncari

(b) Address 6025 Old Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert St.

19 AUG 14 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1945 to 8/13 1945, and that I last saw h[illegible] alive on 8/13 1945.

	Duration
Immediate cause of death Cardio-respiratory failure	24 hrs.
Due to Carcinoma of the breast & metastasis - pathological	2 yrs. +
Due to Cerebral embolism	
Other Conditions Debilitation	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David J. Bell, Jr. M. D.

Address Mercy Hospital Date signed 8/13/45

VS 150

G31532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G31532

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 S. Kenwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 S. Kenwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gore – or Gora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Josephine Gore or Gora
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Jan 7 1894

8. AGE: Years	Months	Days	If less than one day
51	7	4	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation pipe fitter
11. Industry or business Bethlehem Shipyard

FATHER
12. Name Florgen gora
13. Birthplace Poland.

MOTHER
14. Maiden Name Catherine
15. Birthplace Poland.

16 (a) Informant Mrs. Josephine Gore
(b) Address 1002 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 '45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross, Annt R
Location Annapolis Road

18 (a) Funeral director Stephen J. Fahrenholz
(b) Address 1000 S. Kenwood Ave

AUG 14 1945 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to Aug 11 1945 and that I last saw him alive on Aug 11 1945.

Immediate cause of death	Duration
Metastatic Carcinoma of rt lung.	
Due to Cong. at site of chronic osteomyelitis of rt leg.	
Due to	
Other Conditions amputation rt leg at knee	

(Include pregnancy within 3 months of death)
Date of operation 1944 at Johns Hopkins
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Lightfoot M. D.
Address 432 N. Bethel St. Date signed 8/13/45

VS 150

G31533

JO #93192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G31533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 207-10-2215

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Clayton Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1916

8. AGE: Years	Months	Days	If less than one day
29	6	28	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Craver
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Amelia Baumann
15. Birthplace Pennsylvania

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Patton, Pa.

18 (a) Funeral director Elmer H. Conklin & Co.
(b) Address 924 E. Eager St.

AUG 14 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1945, at 3:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19, 1945 to Aug. 13, 1945, and that I last saw her alive on Apr. 12, 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland M.D.
Address Balto City Hosp Date signed 8/13/45

VS 150

G31534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31534

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A.
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Bayside Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: FRED William Winters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 | 29 | 1867

8. AGE: Years 78 | Months 0 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Sweden (Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business & Seaman.

FATHER
12. Name (Not Known) Winters
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant August Klacka
(b) Address 542 Lakewood Ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 8/14/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Trinity
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 AUG 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 8:16 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1945 to Aug 13 1945 and that I last saw him alive on Aug 13 1945

Immediate cause of death: Cerebral vascular accident — Duration:

Due to: Hypertension yrs

Due to: Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Schlick

Address 1213 Light St Date signed 8/13/45

VS 150

G31535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No. G31535

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7211 Potter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Male	White	Divorced

6 (b) Name of ~~husband or~~ wife Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1891

8. AGE: Years	Months	Days	If less than one day
54	2	11 12	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self

FATHER
12. Name Chas. T. Baldwin
13. Birthplace Md.

MOTHER
14. Maiden Name Alice A. Croxton
15. Birthplace Va.

16 (a) Informant Alice A. Croxton
(b) Address 4716 Amberly Ave.

17 (a) Burial (b) Date thereof 8/15/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1947 St. Paul St.

(a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

AUG 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945, at 6 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions Multiple fractures, lacerations and bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-45 at A. M.
(b) Where did injury occur? Baltimore City Hospital
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Jumped from window.

23. Signature Howard R. Bruenner M.D.
Medical Examiner.

Date signed 8-13-45

VS 151

G31536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G31536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 S. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 S. Monroe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ADOLPH K. W. MAHN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1877

8. AGE: Years	Months	Days	If less than one day
67 77	10 28	4	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business Self

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant George Clatterbuck
(b) Address 124 S. Monroe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns, Elliott City
Location Elliott City, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 14 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Aug 13 1945
and that I last saw h alive on Aug 12 1945

Immediate cause of death	Duration
Myocarditis + Toxemia	1 wk
Due to Probably Malignancy Stomach	
Due to	
Other Conditions Carcinoma Pylorus	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Kahn M.D.
Address 1027 W. Mt St Date signed 8/13/45

VS 150

X

G31537 E. Grossman 1212 N. Patterson Park Ave 46 2933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 N. Rose st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 N. Rose st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Rowles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Anna R. Rowles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21st 1865

8. AGE: Years	Months	Days	If less than one day
80	5	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Harness Maker

FATHER
12. Name (Unknown) Rowles
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Louisa (Unknown)
15. Birthplace

16 (a) Informant Harry F. Rowles
(b) Address 1514 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 14 1945 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11th 1945, at 4 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20/45 19 , to 8/11 1945
and that I last saw h i m alive on 8/11 1945

Immediate cause of death	Duration
Coronary Thrombosis	2 hours
Due to Coronary artery Disease	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Karl Grossman M. D.
Address 1212 N Patt. Pk. Date signed 8/13/45

VS 180

x E. Grossman

G31538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 W. 37th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 W. 37th St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Eugene S. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-9900

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Ella Boylan Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28th 1868

8. AGE: Years	Months	Days	If less than one day
77	3	13	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Textile Worker
11. Industry or business Hooper Mills

FATHER
12. Name John Harris
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Derr
15. Birthplace Pa.

16 (a) Informant Ella Harris
(b) Address 1027 W. 37th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/16/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md

18 (a) Funeral director William Cook Inc.
(b) Address 1317 St. Paul St.

19 AUG 14 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7th 1945 to Aug 11th 1945; and that I last saw him alive on Aug 11th 1945.

Immediate cause of death Acute Cardiac Failure — Duration 4 hrs.

Due to Cardio-Renal involvement — Duration

Due to Hypertension & Chronic Cardiac — Duration 1 yrs

Due to Hypertension & Arteriosclerosis — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide No.
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Reich M.D.
Address 304 Falls Rd. Date signed 8/14/45

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31539 A-45624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104B

Registered No. G31539

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnnie Wray Prodgrass

3 (b) If veteran; name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-44

8. AGE: Years	Months	Days	If less than one day
	9	4	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harvey Prodgrass
13. Birthplace Virginia

MOTHER
14. Maiden Name Vitbus Phelps
15. Birthplace Virginia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory SUNSET
Location BECKLEY W. VA.

18 (a) Funeral director Williams Cosby Inc.
(b) Address 1217 Kanawha St. Beckley W. Va.

AUG 14 1945 (Date rec'd by registrar)

(b) Huntington Williamson, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1945 to 8-13 1945; and that I last saw h alive on 8-13 1945

Immediate cause of death	Duration
Terminable Circulatory failure	
Due to Multiple cerebro thrombosis	
Due to Septicemia & dehydration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond M. D.
Address V. H. H. Date signed

VS 150

G31540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a (rev)

Registered No. G31540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town Severn
(If outside city or town limits, write RURAL and give town)
(d) Street Box 135
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Etta Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles A. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~12/11/1882~~ Jan. 11, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business OWN Home.

FATHER
12. Name ~~August Niemann~~ Niemann
13. Birthplace England

MOTHER
14. Maiden Name ~~Augusta Siebold~~ Subo
15. Birthplace Maryland

16 (a) Informant Charles A. Johnson
(b) Address Severn, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16 (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location Baltimore, Md

18 (a) Funeral director Thomas W. Pinkstaff
(b) Address Glen Burnie, Md.

19 (a) G 14 164 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1945, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1945, to 8/14 1945, and that I last saw her alive on 8/14 1945.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis M. Ordon, M. D.
Address 2731 N. Calvert St. Date signed Aug. 14, 45

VS 150

G31541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31541

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1138 Mosher St

(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1138 Mosher St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Thomas Bullock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-7-1903

8. AGE: Years 42 | Months — | Days 6 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER 12. Name Henry Bullock

13. Birthplace S.C.

MOTHER 14. Maiden Name Corelious ?

15. Birthplace S.C.

16 (a) Informant Fannie Bullock

(b) Address 1138 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 16 45 (month) (day) (year)

(c) Cemetery or crematory Lebanon Mem Park

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

19 AUG 14 1945 (Date rec'd by Registrar) Hunter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945 at 9:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2- 1945 to 8-13 1945, and that I last saw h[illegible] alive on 8-13- 1945.

Immediate cause of death Cardio-Renal Disease

Due to Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 Mos

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. T. Jackson M.D.

Address 1100 Madison Ave Date signed 8/14/45

VS 150

G31542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G31542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 E. 25th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 E 25th Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Parr Diggs

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband: J. Ross Diggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 22nd 1848

8. AGE: Years 96 | Months 7 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isreal M. Parr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary B. Pope
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary C. Diggs Miller
(b) Address 107 E 25th Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 15-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) [illegible] (Signature of Registrar) Huntington Williams, M.D. Registrar

AUG 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12th 1945, at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1944 to Aug 13 1945 and that I last saw h[illegible] alive on Aug 13 1945.

Immediate cause of death	Duration
Myocarditis chronic	Unknown
Heart Block	Unknown
Due to Arteriosclerosis	Unknown
Due to Senility	
Other Conditions Nephritis: Acerata	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William A. Lentze, M. D.
Address 1500 Aisquith St Date signed 8/14/45
Baltimore, Md.

G31543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 N. Bruce St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19 —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Christiana Giles

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: George Giles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1874

8. AGE: Years 71 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Dom —

11. Industry or business

FATHER 12. Name Wesley Chase
13. Birthplace Md.

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant George Giles
(b) Address 517 N Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 303 Preston

19 AUG 14 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1944, to 8-11 1945, and that I last saw her alive on Aug 9 1945.

Immediate cause of death: Hypertensive Heart Disease.
Due to: nephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 631 W Franklin Date signed 8/13/45

VS 150

G31544 GATES G31544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 Woodward at
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandra Gates ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/10/1945

8. AGE: Years — | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles Gates
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Christie Ward
15. Birthplace Carroll Md.

16 (a) Informant Christie Gates
(b) Address 841 Woodward at

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)
(c) Cemetery or crematory Savage.
Location Savage. Md.

18 (a) Funeral director Ambrose Dye
(b) Address 414 N Franklintown rd.

AUG 14 1945 (Stamped by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1945, at 11 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1945 to 8/13 1945, and that I last saw her alive on 8/13 1945

Immediate cause of death	Duration
Bronchopneumonia, terminal	12 hrs.
Due to Diarrhoea, dehydration, cardiac	2 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sam

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Mark M.D.

Address University Hosp. Date signed 8/14/45

VS 150

G31545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G31545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Druid Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Major Matthias Mathis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20th 1925

8. AGE: Years	Months	Days	If less than one day
20	2	23	hr. min.

9. Birthplace Penn (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Glen Martin

FATHER 12. Name Jeff Mathis
13. Birthplace Penn

MOTHER 14. Maiden Name Lizzie Beal
15. Birthplace Penn

16 (a). Informant Jeff Mathis
(b) Address Penn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14th 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Manristown Penn

18 (a) Funeral director Lee D. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) AUG 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 7 P. M.

21. I certify that I took charge of the remains described above, held an Inspection of Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Crushed Vertebra
Due to Multiple fractures

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/4
(a) Date of injury 8-12 45 at 6:15 P. M.
(b) Where did injury occur? Philadelphia & Aliceanna Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Motorcycle struck by auto

Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 8-13-45

VS 151

G31546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G31546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 510 S Castle St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 510 S. Castle St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna E Schweiger

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	female	white	widow

6 (b) Name of husband or wife John Schweiger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1. 1886

8. AGE: Years	Months	Days	If less than one day
59	1	12	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation house wife

11. Industry or business at home

FATHER

12. Name Joseph Merphy

13. Birthplace Virginia

MOTHER

14. Maiden Name Johanna Hanson

15. Birthplace Baltimore

16 (a) Informant John W Schweiger Son

(b) Address 510 S Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/45 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location Odonnell St

18 (a) Funeral director Lilly & Geelen Bro.

(b) Address 403. S. Wolfe st

19 (a) (b) Registrar

(Date received by registrar)

AUG 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1945 to Aug 13 1945 and that I last saw h[illegible] alive on Aug 13 1945

Immediate cause of death	Duration
CEREBRAL HEMORRAGE	AUG 7, 1945
Due to	
Due to ARTERIAL HYPERTONSION	? ?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph F. Deegan M. D.

Address 211 Lebanon St Date signed 8/14/45

G31547

Lot and # 14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G31547

Found – Pier #8 Light Street

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Unknown (b) County
(c) City or town Unknown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Male

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	COLORED	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
55?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 14 1945 (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 19 45 at 9 1/2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-1-45 at 22/1 M.
(b) Where did injury occur Found: Pier #8 Light St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found Drowned

23. Signature Robert A. Foster M.D. Medical Examiner.
Date signed August 9, 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31548 Lenard #13 G31548

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. a. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Cleveland (If outside city or town limits, write RURAL and give town)
(d) Street No. 6613 Lenwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Earl Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY AUG 13 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 AUG 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1945 - 9:13 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-22-45 at 4:30 P. M. 25/5

(b) Where did injury occur Bridge "Between" Standard Guano Co. Curtis Bay

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.

(d) Means of injury Found Drowned.

23. Signature Robert A. Foster M.D. Medical Examiner.

Date signed July 23, 1945

VS 151

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G31549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4205 Groveland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4205 Groveland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustave A Bueschel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or divorced:
M	W.	Widowed

6 (b) Name of husband or wife Sarah Cope Bueschel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22-1854

8. AGE: Years	Months	Days	If less than one day
91	4	20	hr. min.

9. Birthplace Baden Germany
(Town, county, and State)
10. Usual Occupation Retired (Grocer)
11. Industry or business

FATHER
12. Name Gustave Bueschel
13. Birthplace Germany

MOTHER
14. Maiden Name Conyers
15. Birthplace Germany

16 (a) Informant Mrs Walter Wolle
(b) Address 4206 Groveland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Bertram & Sons
(b) Address 2324 N Charles St.
(c) Huntington Williams Mgr
(Signature of Registrar) Registrar

AUG 14 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1945, at 5 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ 4-5 Years 19..., and that I last saw him alive on 8/12 1945.

Immediate cause of death
Ingestion of Gasoline
Due to Malignancy Larynx
Due to
Other Conditions Mitral regurgitation
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 yrs.
Many yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jesse Cordell
Address 3902 Groveland Ave Date signed 8/13/45 M D

15 X

G31550 ✓ G31550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 N. Caroline street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Caroline street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS F. DOHONY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife: Maggie C. Dohony
6 (c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): June 6, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	7	hr. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)
10. Usual Occupation: Retired Guard
11. Industry or business: Md. Penitentiary

FATHER
12. Name: Nicholas Dohony
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Eliza Purcell
15. Birthplace: Ireland

16 (a) Informant: Mrs. Maggie C. Dohony
(b) Address: 1628 N. Caroline street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/16/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas J. Evans & Son, Inc.
(b) Address: 118 W. Mt. Royal Ave

19 (a) (Date received by Registrar) AUG 14 1945 (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 13 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 45 to Aug 13 19 45 and that I last saw him alive on Aug 13 19 45

	Duration
Immediate cause of death: Carcinoma of Prostate Gland	
Due to: Hypertensive Cardiovascular Disease	June 45
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Fred Ruzicka M. D.
Address: 700 N Bolton Ave Date signed: 8-14-45

G31551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31551
Registered No.

87c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Swallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary Whitford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1866

8. AGE: Years	Months	Days	If less than one day
79 79	0	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name George Swallwood
13. Birthplace Balto

MOTHER 14. Maiden Name Salome Martin
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winkfield
(b) Address 914 Greenmount Ave

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, MD

DEC 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1945 at 6 A-M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Aug 3 1945
and that I last saw [illegible] alive on June 3 1945

Immediate cause of death Acute Renal Kidney Condition

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration
+ 1 day
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto H Deukes M. D.
Address 9282 North Ave Date signed 8/14/45

G31552

JO #94968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G31552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Honson or John Hanson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	-0-	-4-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Honson (d)
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Anne Thompson (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cemetery
Location O'Donnell St.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) 1.4.1945 (Date rec'd by registrar) (b) Huntington Millcastle, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1945, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24, 1945 to Aug. 10, 1945. and that I last saw h im alive on Aug. 10, 1945.

Immediate cause of death: Laennec's cirrhosis of liver — Duration

Due to alcoholism and poor dietary intake.

Due to

Other Conditions Bronchial pulmonary infection (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: not obtained

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 8/14/45

G31553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 E. 35th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 E. 35th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Harry W. Sanders.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6-1903

8. AGE: Years 41 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Personal Engrav'g & Stamp Co.

FATHER
12. Name George H Sanders
13. Birthplace Balto

MOTHER
14. Maiden Name Minnie A Heisel
15. Birthplace Balto

16 (a) Informant Mrs Alice Reinke
(b) Address 621 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Balto

18 (a) Funeral director Wm Cook Inc
(b) Address 1012 St Paul St

19 (a) (Date received by registrar) (b) Registrar

AUG 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945, to 8/10 1945, and that I last saw him alive on 8/10 1946.

Immediate cause of death Coronary occlusion. — Duration Sudden

Due to Hypertension, arteriosclerosis. —

Due to —

Other Conditions Epilepsy. — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Gwynn
Address 3963 Greenmount Ave Date signed 8/13/45

X

G31554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH — 46E

G31554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2023 Ramsay Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 or 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2023 Ramsay Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Koehler (Koehler)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-2856

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Margaret Koehler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-17-1875

8. AGE: Years	Months	Days	If less than one day
70	2	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Lumber

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs Margaret Koehler
(b) Address 2023 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 15-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director George L. Schwab
(b) Address 1101 Frederick Ave

AUG 14 1945

19 AUG 15 1945 (b) Huntington Mills, Md.
Registrar

VS 150

AUG 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1945, to Aug. 13 1945, and that I last saw h.im alive on Aug 11 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 wks.
Due to Gen'l Arteriosclerosis	
Due to	
Other Conditions Carcinoma of Desc. Colon. (Include pregnancy within 3 months of death)	
Date of operation —	
Major findings of operation: —	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas. Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 8/14/45

X

G31555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31555

To 294624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Haines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1945

8. AGE: Years	Months	Days	If less than one day
---	-1-	-4-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucille Powell
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremated 3 PM (Burial, cremation, or removal) (b) Date thereof 8-11-1945 (month) (day) (year)
(c) ~~Cemetery~~ or crematory Baltimore City Hosp.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 AUG 15 1945 Huntington Williams M.D.
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1945, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7, 1945 to July 27, 1945, and that I last saw him alive on July 27, 1945

Immediate cause of death Toxic Hepatitis — Duration 4 weeks

Due to ?

~~Due to~~

Other Conditions Diarrhea, Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not Done

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Baylutt M. D.
Address Balt. City Hosp. Date signed 8/13/45

161c

G31556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G31556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4160 Pimlico Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 41 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4160 Pimlico Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE S. SCHWARTZ

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife SAMUEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name DAVID

13. Birthplace RUSSIA

MOTHER 14. Maiden Name DORA

15. Birthplace RUSSIA

16 (a) Informant HUSBAND

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-15-45 (month) (day) (year)

(c) Cemetery or crematory North Point RD

Location North Pt. Rd.

18 (a) Funeral director Jack Lewis Inc

(b) Address 1432 E. Baltimore St

19 AUG 15 1945 (b) Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Aug 14 1945; and that I last saw her alive on July 30 45

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Abrahamson MD

Address 601 N. Howard St Date signed 8/17/45

VS 180

G31557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

Registered No. G31557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So. Balto. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Presbury St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Melvin Lieberman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 27 | 32

8. AGE: Years	Months	Days	If less than one day
12 13	7	17	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Julius
13. Birthplace Russia

MOTHER
14. Maiden Name Eva
15. Birthplace Russia

16 (a) Informant Julius Lieberman
(b) Address 2411 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Woodlawn Mem Pk

18 (a) Funeral director Jack Levin
(b) Address 1439 E. Balto St

19 (a) AUG 15 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1945 to Aug 13 1945 and that I last saw h[illegible] alive on Aug 13 45

Immediate cause of death: Acute Bronchial Asthma.
Due to (status asthmaticus)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration: 1

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Ulrich M. D.
Address 1213 Light St. Date signed

X

631558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

Registered No. 631558

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2816 Brantley RD (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ROBERT BOGASH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Pittsburgh Pa (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Louis

13. Birthplace Russia

MOTHER 14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-45 (month) (day) (year)

(c) Cemetery or crematory Levey Funeralchapel

Location Balto St

18 (a) Funeral director Jack Lewis Inc

Address 1439 E. Baltimore St.

AUG 15 1945 (Date rec'd by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 11:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 13 1945 to August 13 1945, and that I last saw him alive on Aug 13 1945.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to Hypertension, arteriosclerotic heart disease	
Due to	
Other Conditions –	

(Include pregnancy within 3 months of death)

Date of operation –

Major findings of operation: –

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Schecter M. D.

Address Sinai Hospital, Balto, Md. Date signed Aug 14, 1945

VS 180

X

G31559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117B

G31559 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 Normandy Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Normandy Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Jamie Pearce Blakeney
3 (b) If veteran, name war — 3 (c) Social Security Account No. —
4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Albert N. Blakeney 6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 27. 1872
8. AGE: Years 73 Months 3 Days 16 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business
FATHER 12. Name William Pearce
13. Birthplace Maryland
MOTHER 14. Maiden Name Sarah France
15. Birthplace Maryland
16 (a) Informant Albert N. Blakeney
(b) Address 2744 N. 5th St. Harrisburg Pa.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15. 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
AUG 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13. 1945 at 2-20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 16 1944 to Aug. 13 1945 and that I last saw her alive on Aug. 13 1945

Immediate cause of death
1) - Duodenal Ulcer
a Partial obstruction.
Due to
Due to
Other Conditions 1) Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: —

Duration
5 yrs
4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 8/15/45

G31560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G31560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Hickory Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Barbara Ellen Neal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hiram Franklin Neal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24-1868

8. AGE: Years 77 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John R. Sours
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Mrs. Rose Ellen Johnson
(b) Address 3508 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Hills
Location Laurel, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) AUG 15 1945 (Date received by registrar) (b) Huntington Willi (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13- 1945 at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to Aug 13 1945 and that I last saw her alive on Aug 13 1945

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	?
Due to Heart failure	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Wallenstein M.D.
Address 8 S 8 St W 36 Date signed 8/15/45

VS 150

G31561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 N. Payson St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Peter Joseph Nebel.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Clara M. Nebel

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Feb 20- 1862

8. AGE: Years 83 | Months 5 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John F. Nebel
13. Birthplace Germany

MOTHER
14. Maiden Name Annie E Fait
15. Birthplace Germany.

16 (a) Informant Clara M. Nebel
(b) Address 2001 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) Date received AUG 15 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13- 1945 at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25- 1943 to August 13 1945, and that I last saw h~~im~~ alive on August 12- 1945

Immediate cause of death: Chronic Interstitial Nephritis — Duration: unknown
Due to: Hypertension — Duration: unknown
Due to — Duration:
Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Rikards, Jr. M. D.
Address 2532 Edmondson Ave Date signed 8-13-45

G31562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G31562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy H. Metzel

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Dr. Roscoe C. Metzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	5	hr. min.

9. Birthplace Fawn Grove, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustus Hines
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Webster
15. Birthplace Md.

16 (a) Informant Mr. John Metzel
(b) Address 2826 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,
(b) Address North & Pa. Aves.

19 (a) AUG 15 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1945, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945, to Aug 12 1945, and that I last saw h[er] alive on Aug 12 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Due to: Hypertension — Duration: Unknown
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Ashman M.D.
Address 824 W North Ave Date signed 8/14/45

Harris. Ashman

VS 150

631563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 Penhurst ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Waller

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lydia Cline Waller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26-1878

8. AGE: Years 66 | Months 11 | Days 19 | If less than one day: hr. min.

9. Birthplace Neosha, Mo. (Town, county, and state)

10. Usual Occupation Retired Barber

11. Industry or business

FATHER
12. Name Thomas Waller
13. Birthplace Not Known

MOTHER
14. Maiden Name Sarah Holman
15. Birthplace Not known

16 (a) Informant Mrs. Lydia C. Waller
(b) Address 4115 Penhurst Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (c) AUG 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1945 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1945 to 8-14 1945, and that I last saw him alive on 8-14 1945.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to Arteriosclerotic C.V.D.

Other Conditions Acute Hemorrhage Pancreatitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 8-14-45

VS 150

G31564

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered G31564

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kilbeas & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 82 Mellor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Young

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife L. Viola Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 12th 1904

8. AGE: Years	Months	Days	If less than one day
40	9	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Electrical Contractor
11. Industry or business Self

FATHER
12. Name William A. Young
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Willett
15. Birthplace Md Baltimore, Md.

16 (a) Informant Mrs. L. Viola Young
(b) Address 82 Mellor Ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 17-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Ayes.

19 AUG 15 1945 (Date rec'd by local registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1945 at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1945 to Aug 13 1945 and that I last saw ~~him~~ alive on Aug. 13 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 wks
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Stegmaier
Address 1945 W. Balto St. Date signed 8/13/45 M.D.

VS 150

Dr E.J.B. Davis - Edward J. Cameron, M.D. X

G31565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G31565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1893

8. AGE: Years 52 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace White Stone, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Jones
13. Birthplace White Stone Va

MOTHER
14. Maiden Name Elmira Smith
15. Birthplace White Stone Va

16 (a) Informant Alexander Coleman
(b) Address 1532 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lenora A. Holland
(b) Address 1637 Druid Hill Ave

19 (a) AUG 15 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 19X5, at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1X 19X5, to Aug 11 19X5, and that I last saw h[illegible] alive on Aug 11 19X5.

Immediate cause of death Cardio Vascular Renal Disease — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Williams Fay M.D.
Address 1921 Bruns St. Date signed 8/14/45

X

G31566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G31566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1912 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David F. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1873

8. AGE: Years 72 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Charles City, Va. (Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name Robert Johnson

13. Birthplace Va

MOTHER 14. Maiden Name Jennie ??

15. Birthplace

16 (a) Informant Mrs. Jennie Johnson

(b) Address 1912 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk

Location Balto. Co. Md.

18 (a) Funeral director Mrs. George A. Hall

(b) Address 1601 Arbutus Hill Ave.

19 (a) Date received by Registrar AUG 15 1945 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 45 19 at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 19 44 to Aug 12 1945 and that I last saw h alive on Aug 10 45 19

Immediate cause of death Hypertension Coronary Renal Arteriosclerosis — Duration 2 yr.

Due to

Due to

Other Conditions Generalized Arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Adams Gibson, M. D.

Address 312 E 23rd St Date signed Aug 15 45

X

G31567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 N Glover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 N Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna B. Brogan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~ married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Wm J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 1893

8. AGE: Years 52 | Months 6 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ludwig Lenz
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Schlick
15. Birthplace Baltimore Md

16 (a) Informant William J. Brogan
(b) Address 10 N Glover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Belair Rd

18 (a) Funeral director Estate Morgan
(b) Address 3000 E Baltimore St

AUG 15 1945 (Date received by Registrar) (b) Hunting Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13. 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to July 23 1945.
and that I last saw h~~e~~r alive on July 23 1945.

Immediate cause of death: Coronary Occlusion — Duration: 2

Due to: Arteriosclerosis — 2 years
& Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Tantum M. D.
Address 100 N Milton Ave Date signed 8/10/45

X

631568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 631568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Ave
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1945

8. AGE: Years	Months	Days	If less than one day
		5 6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Harry Newton.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence Emory.
15. Birthplace Baltimore, Md

16 (a) Informant Harry Newton.
(b) Address 919 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Kate R Williams

(b) Address 322 N Schroeder St

AUG 15 1945 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1945, at 3:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1945 to Aug 10 1945, and that I last saw her alive on Aug 10 1945

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Robert Mantz M. D.
Address Univ. Hosp Date signed 8/19/45

X

G31569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G31569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 E. Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Tatman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Doris E. Wesley
(b) Address 29 E. Lee St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 AUG 15 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Sub-dural Hemorrhage
a or cerebral Hemorrhage
Due to Bruises of scalp

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1:15 AM at 8-6-45 M.
(b) Where did injury occur? 619 Light St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Struck on head with blunt instrument

23. Signature Howard A. Andersch M.D.
Medical Examiner.
Date signed 8-13-45

G31570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G31570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ru... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospt
(c) Hospital or institution: Monument St 6-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ISRAEL LEVIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-03-6253

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Baila
15. Birthplace Russia.

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Dorsey & Pulaski Sts

18 (a) Funeral director Jack Levin
(b) Address 1439 E. Baltimore St Huntington Williams, Md

19 (a) AUG 15 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945 at 11 46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Pulmonary edema & Congestion

Due to Myocardial insufficiency

Due to

Other Conditions Acute congestion of viscera

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Hamburger
Address Sinai Hospital Date signed 8/14/45

VS 150

C31571
478727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C31571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A. County
(c) City or town Ft. Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-45

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Braun
13. Birthplace Ga.

MOTHER
14. Maiden Name Betty Granger
15. Birthplace U.S.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (Month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Ave. Balto.

18 (a) Funeral director John O. Mitchell Undertaking Inc.
(b) Address 1700 Eutaw Place

19 (a) AUG 15 1945
(Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1945, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1945, to Aug. 14 1945, and that I last saw him alive on Aug. 14 1945.

Immediate cause of death Uremia

Due to ? congenital abnormality of the kidneys

Due to

Other Conditions Heart failure
Aspiration pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/15/45

VS 150

157 H

G31572

BALTIMORE CITY HEALTH DEPARTMENT Maxey

CERTIFICATE OF DEATH 93

Registered No. G31572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Maryland Ave
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Md-Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer L. Maxey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 237-16-9057

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 1917

8. AGE: Years	Months	Days	If less than one day
34	5	22	hr. min.

9. Birthplace Dalson New Mexico (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name James W Maxey
13. Birthplace Marion Virginia

MOTHER
14. Maiden Name Alice Radcliff
15. Birthplace England

16 (a) Informant Mrs Ely C Maxey
(b) Address 2119 Maryland Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/15/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Westminster Md

18 (a) Funeral director A. LEE OFER
(b) Address 4644 York Rd

19 (a) AUG 16 1945 (b) Huntingdon Williamsport, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1945 at 5:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Uhrich M.D. Medical Examiner.
Date signed 8-15-45

VS 151

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

✓ G31573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Pulaski St
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 65
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna M. Felte

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Fred W. Felte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1870

8. AGE: Years 75 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Back

13. Birthplace Germany

MOTHER 14. Maiden Name Anna -

15. Birthplace Germany

16 (a) Informant Fred W. Felte (Son)

(b) Address 319 S. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Lt. Cr. B. M. Walters

(b) Address Park & Stricker Sts

19 AUG 16 1945 (Date rec'd by Registrar) Chas. Wellington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to Aug 13 1945, and that I last saw h[illegible] alive on Aug 13 1945.

Immediate cause of death Pulmonary Oedema

Due to Nephrosclerosis

Due to Chronic Interstitial Nephritis Hypertensive

Other Conditions Acute Bronchitis Both Lungs

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

Duration: 4 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Kahler M.D.

Address 7027 W Pratt St Date signed 8/15/45

VS 150

G31574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G31574
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lang

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1945 at 6 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of Aorta

Due to Syphilitic Aortitis

Other Conditions Far advanced tuberculosis left upper lobe
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed August 3rd 1945

2895

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G31575 Registered No.

JO #63865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 10mos. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Y.M.C.A. South Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chris Platt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	-0-	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace Norway

MOTHER
14. Maiden Name Maria (d.)
15. Birthplace Norway

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 16 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1945, at 9:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17, 1943, to July 30, 1945, and that I last saw him alive on July 30, 1945.

Immediate cause of death	Duration
Inanition	
Due to Esophageal diverticulum	4 mo.
Due to	
Other Conditions Tuberculosis of Lumbar Spine	2 yr.

(Include pregnancy within 3 months of death)

Date of operation 4-10-45
Major findings of operation: Esophageal diverticulum
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence J. Cowell M. D.
Address Balto City Hosps. Date signed 8-16-45

12894 X

G31576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Bunen St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Mace Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Sarah Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
58				

9. Birthplace (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945 to 8/3 1945
and that I last saw h alive on 8/3 1945

Immediate cause of death Cardiac failure
Due to Myocarditis Chronic Nephritis
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. MacMurchy M.D.
Address 801 Bunen St Date signed 8-13-45

X

631577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

631577 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 CURTIS AVE. BALTO 26 (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] (ZELMA) MOORE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife LEMUEL M. MOORE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 26, 1870

8. AGE: Years	Months	Days	If less than one day
74	9	14 19	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN ROBINSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SARAH WOODS
15. Birthplace MARYLAND

16 (a) Informant Mrs Mary Doan
(b) Address 2124 Barkley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or crematory Marley M. P. Church
Location A. A. Co.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (Registrar's signature) AUG 16 1945 Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 15 1945 at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 13 1945 to AUG 15 1945 and that I last saw HER alive on AUG 15 1945.

Immediate cause of death	Duration
BRONCHOPNEUMONIA WITH PLEURAL EFFUSION	
Due to UREMIA + CARDIAC FAILURE	
Due to gastric carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W K Dunney M D
Address Union Mem Hosp Date signed 8/15/45 M. D.

VS 150

X

G31578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31578

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 Baker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Llewelyn Hulbert Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mabel F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1884

8. AGE: Years 61 Months 3 Days 8 If less than one day hr. min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Lillian Butler
(b) Address 612 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George W. Holland
(b) Address 1637 Druid Hill Ave. Huntington Williams, Mgr.

AUG 16 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/45 19 at 1P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 19 45 to 8/12 19 45 and that I last saw him alive on 8/12/45

Immediate cause of death	Duration
Due to Uremia	
Due to Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh Cowe M. D.

Address 1131 Hanlon Date signed 8/14/45

VS 150

G31579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G31579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Cutler Ave.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Belnord Ave-34 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Trabert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1945

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Jos. Trabert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillian Rosenthal
15. Birthplace New York

16 (a) Informant Lillian Trabert
(b) Address 427 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Chas. G. Miller
(b) Address 2334 Jefferson St.

19 (a) AUG 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1945, at 5.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1945, to Aug 14 1945, and that I last saw h alive on Aug 14 1945.

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Date signed

G31580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G31580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2424 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-45

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace BALTO, MD.
(Town, county, and state)

10. Usual Occupation O

11. Industry or business O

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Miss MILDRED MILLER
15. Birthplace Penna

16 (a) Informant SAME
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 16 1945 (b) Hunterston Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8 1945, at 6:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1945 to 8-8 1945, and that I last saw him alive on 8-7 1945.

Immediate cause of death	Duration
PREMATURITY	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchijah Spragins M. D.
Address U.M.H. Date signed 8-8-45

VS 180

F-898

X

G31581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G31581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 55 Kingston Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Jane Greer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1945

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Russell Greer
13. Birthplace Virginia

MOTHER
14. Maiden Name Jane Lawson
15. Birthplace Virginia

16 (a) Informant Hospital records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 16 1945 (Date rec'd by registrar) Herbert A. Williams, M.D.

VS 160

12-897

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1945 to Aug. 5 1945, and that I last saw him alive on Aug. 5 1945.

Immediate cause of death	Duration
atelectasis, partial	
? intracranial hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

G31582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turner's Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 875 Avondale Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Steele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1945

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Pearl Steele
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

JOHNS HOPKINS MEDICAL SCHOOL AUG 14 1945

18 (a) Funeral director
(b) Address

Commissioner of Health

19 AUG 16 1945 (Date rec'd by registrar) Timothy [illegible] Williams M.D. Registrar

VS 180

5896

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1945, to Aug. 6 1945, and that I last saw him alive on Aug. 6 1945.

Immediate cause of death prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

G31583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G31583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 N Caton Ave
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N Caton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha E. Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of ~~husband or~~ wife Harry L. Hudson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1882

8. AGE: Years	Months	Days	If less than one day
63	3	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William T. Eggen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant James R. Hudson
(b) Address 614 Cooks Lane

17 (a) Burial (b) Date thereof 8/16/45
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St Huntington Williams, Mgr.

19 (a) AUG 16 1945 (b)
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1945 to Aug 13 1945, and that I last saw her alive on Aug 13 1945.

Immediate cause of death Pulmonary edema

Due to Acute Congestive Heart Failure

Due to (Antecedent causes)

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Bobby F. Cowan M. D.
Address Franklin Square Hosp. Date signed 8/15/45

Ph. F. H.S. Ouch. Howard L. Mackert M.D.

G31584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursery Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Same. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2-1867

8. AGE: Years	Months	Days	If less than one day
78	✓	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business —

FATHER
12. Name Jesse Clayton
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. J. Cowley
(b) Address Same St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Oak Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Oak Md.

19 (a) (b)

(Signature of Registrar)

AUG 16 1945 Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1945, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945, to Aug 14 1945, and that I last saw him alive on Aug 14 1945.

Immediate cause of death Chronic myocarditis

Duration

Due to

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. N. Cretterman M.D.

Address 7324 Reisterstown Rd Date signed 8/15/45

X

G31585
478284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G31585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Edythale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Arthur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-87

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Ryan
13. Birthplace 2 2

MOTHER
14. Maiden Name Minerva Worley
15. Birthplace 2 2

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Bayard Virginia K. Knight
(b) Address 721 Pleasant St

19 (a) AUG 16 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 10.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-4 1945 to Aug-12 1945 and that I last saw h alive on Aug-12 1945.

Immediate cause of death	Duration
Uremia	
Due to Carcinoma of Cervix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph R. Stevens M. D.
Address Hopkins Hospital Date signed 8-12-45

VS 150

X

G31586 ✓ G31586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Cornell
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Cornell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ingrite Jackson Holland.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Sylvester Holland

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 17 1904

8. AGE: Years 41 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Plummer Jackson

13. Birthplace N. C.

MOTHER 14. Maiden Name Louisa Frost

15. Birthplace Balto Md.

16 (a) Informant Mable Thompson

(b) Address 1127 Cornell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem. Co.

Location Balto Co. Md.

18 (a) Funeral director Raymond Magruder Wright

(b) Address 721 Aisquith St

19 (a) AUG 16 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-45 19 , at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1945 to 8-12 1945, and that I last saw h[illegible] alive on 8-10-45 19

Immediate cause of death: Cerebral Hemorrhage — Duration Suddenly

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Adams M. D.

Address 312 E 23rd Date signed 8-14-45

VS 150

Maurice Adams

G31587

CWK-83830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 10- 27
(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME William Lew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Chinese	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3-1922

8. AGE: Years	Months	Days	If less than one day
22	9	10	hr. min.

9. Birthplace China (Town, county, and state)

10. Usual Occupation School Student

11. Industry or business

FATHER
12. Name Wing Chin De Chang
13. Birthplace China

MOTHER
14. Maiden Name Toy See
15. Birthplace China

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 - 17 - 45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City.

19 (a) AUG 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 13 1945, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1943 to Aug. 13 1945, and that I last saw him alive on Aug. 13 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balto. City Hosp. Date signed 8/14/45

VS 150

2020 N. Charles St.

G31588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood Nursing Home
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Roesch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George J. Roesch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Thomas F. McLaughlin
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Ella Calvin
15. Birthplace Balto Md.

16 (a) Informant Mrs. Bessie F. McLaughlin
(b) Address 613 E. 30th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer
Location Baltimore

18 (a) Funeral director Manuel Bros. Inc.
(b) Address 600 W. North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

AUG 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1945 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Aug 15 1945, and that I last saw her alive on Aug 14 1945.

Immediate cause of death	Duration
Hemiplegia 3rd attack	3 days
Due to Arteriosclerosis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 2020 N. Charles Date signed 8/17/45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 631589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Ascension Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Brown

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	M

6 (b) Name of husband or wife Ella
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 8/16 1886

8. AGE: Years	Months	Days	If less than one day
58	11	29	hr. min.

9. Birthplace New Kent Co., Va.
(Town, county, and state)
10. Usual Occupation truck driver
11. Industry or business Md. Beef Provision

FATHER
12. Name William Brown
13. Birthplace Va

MOTHER
14. Maiden Name Molly —
15. Birthplace Va

16 (a) Informant wife
(b) Address 3012 Ascension Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. M. Cof Md.

18 (a) Funeral director Chas H Eyaded
(b) Address 927 N mount st

19 (a) AUG 16 1945 (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1945 to 8/15 1945 and that I last saw h. M alive on 8/15 1945.

Immediate cause of death	Duration
acute urinary supression	2da
Due to lobar pneumonia	
c dehydration	
Due to	
Other Conditions possible uremia	
toxemia.	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P Daemer
Address University Hosp. Date signed 8/15/45

VS 150

631590

478671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

631590

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 10 E. Chase St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Frederick Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-21-62

8. AGE: Years	Months	Days	If less than one day
83	6	45	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER 12. Name Wm James Taylor

13. Birthplace Va.

MOTHER 14. Maiden Name Sophia Ann Miam

15. Birthplace Va.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Aug-16-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Hillsboro, Engenia

18 (a) Funeral director Sam Dreyer, Jones

(b) Address North Pa Aves

19 AUG 16 1945 (b) Transiting for Williamsport Md.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August-16 1945, at 3.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-12 1945, to Aug-16 1945, and that I last saw h[illegible] alive on Aug-16 1945.

Immediate cause of death Non function of Kidneys, Uremia — Duration: Uremia 7 days

Due to Staghorn Calculus - left kidney, Bilateral pyelonephritis — Duration: 2 weeks duration

Due to — Duration:

Other Conditions B. Prateus infection of bladder — Duration:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [signature] M.D.

Address Date signed 8/17/45

G31591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146c

Registered No. G31591

CHK-95452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Yrs

15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N. Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

G 30874

3 (a) FULL NAME Frances Middleton (Chambers)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1912

8. AGE: Years	Months	Days	If less than one day
32	8	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Middleton
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Knotts
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Presstman St

19 (a) Date rec'd by Registrar AUG 1 6 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 - 1945, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1945, to Aug. 16 1945, and that I last saw h er alive on Aug. 16 1945.

Immediate cause of death	Duration
Peripheral Vascular Collapse	
Due to Post Partum Hemorrhage	
Due to Uterine Atony	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: not done
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. T. Rees M.D. M. D.
Address Balt City Hosp. Balt Md. Date signed 8/16/45

X

G31592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58 D

✓ G31592 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 W Montgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irey Meyers

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife James 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/10/ 1919

8. AGE: Years	Months	Days	If less than one day
25	8	4	hr. min.

9. Birthplace Waverly Va (Town, county, and state)
10. Usual Occupation Federal Tin Co
11. Industry or business

FATHER
12. Name Harrid Turner
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant James Meyers
(b) Address 11 W Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co. Md.

18 (a) Funeral director Isaiah L Brown
(b) Address 108 W Montgomery St

19 (a) (Date received by registrar) (b) Huntington Williams Registrar
AUG 16 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1945 at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1945 to 8/14 1945, and that I last saw h.e.r alive on 8/14 1945.

Immediate cause of death Cardiac failure — Duration 2 days

Due to rupture of aortic valve 1 wk

Due to rheumatic pancarditis 2 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic pancarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Doerges M.D.
Address University Hospital Date signed 8/15/45

X

631593

BALTIMORE CITY HEALTH DEPARTMENT ✓ 631593

CERTIFICATE OF DEATH

Registered No. X 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] Rural
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Kess

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	negro	married

6 (b) Name of husband or wife Joseph
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eli Clayton
13. Birthplace Md.

MOTHER
14. Maiden Name Martha (?)
15. Birthplace Md.

16 (a) Informant Joseph Kess
(b) Address Glenburnie R.F.D. 6, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17/45 (month) (day) (year)
(c) Cemetery or crematory Hall. Lt
Location Marley Neck Rd

18 (a) Funeral director Leavitt & Brown
(b) Address 108 W Monument St Huntington Hotel

19 (a) AUG 16 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945 at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 13 1945 to August 13 1945 and that I last saw h.. alive on August 13 1945 9 A.M.

Immediate cause of death	Duration
Cardiac Failure	?
Due to Coronary Occlusion	5 days +
Due to Acute Pyelonephritis	?
Other Conditions Aortic Stenosis, Cardiac Hypertrophy, Coronary Occlusion, Mitral Stenosis (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: None
of autopsy: August 16, 1945

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard T. Kurland M.D.
Address University Hospital Date signed 8/17/45

VS 150

133 B Kurland

G31594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1176

G31594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1500 Spring St~~
(c) Hospital or institution: St Jos Hosp 9/9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race white | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Carrie L Schmidt
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Aug 12 1887

8. AGE: Years 60 | Months — | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER
12. Name Aug L Schmidt
13. Birthplace Balto

MOTHER
14. Maiden Name Dorothy Kreider
15. Birthplace Balto

16 (a) Informant Mrs Carrie L Schmidt
(b) Address 1500 N Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 208 E Orleans St

19 (a) Registered by Registrar Aug 16 1945 Justin Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1945, at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1945 to 8/14 1945.
and that I last saw h alive on 8/14 1945.

Immediate cause of death Cardio Respiratory Failure | Duration

Due to Generalized Peritonitis

Due to Perforated Duodenal ulcer & Gastro Jejunal anastomosis

Other Conditions Pneumonia.
(Include pregnancy within 3 months of death)

Date of operation 8/6/45

Major findings of operation: Duodenal Ulcer

of autopsy: Perforation.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Justin Williams M.D.
Address St Joseph Hospt Date signed 8/14/45

X

VS 180

G31595

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31595

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S Light St
(c) Hospital or institution: St Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8218 Beach Drive
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Waters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Edith Waters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/1893

8. AGE: Years	Months	Days	If less than one day
51 52	9	14	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Own

FATHER
12. Name Arthur Waters
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Charlotte Grimshaw
15. Birthplace Germany

16 (a) Informant Edith Waters
(b) Address 8218 Beach Drive.

17 (a) Burial (b) Date thereof Aug 18 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ellerich Funeral Home
(b) Address 2108 Orleans St

19 (a) (Date received by registrar) AUG 16 1945 (b) Registrar Washington Hollander, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1945, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1945 to Aug 15 1945, and that I last saw him alive on Aug 15 1945.

	Duration
Immediate cause of death Generalized Carcinomatosis	
Due to Carcinoma of Stomach (primary site)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinomatosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Ehrlich M. D.
Address 1213 Light St. Date signed 8-15-45

X

631596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

631596 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1628 N.Washington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N.Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M.Healy

3 (b) If veteran, name war Spanish Am. War

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mary.V.Healy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr.17,1880

8. AGE: Years 65 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Healy
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary---
15. Birthplace ---

16 (a) Informant Mrs.Mary V.Healy
(b) Address 1628 N.Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.17/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Hourigan Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by local registrar) AUG 16 1945 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug.14/45 19 , at 9 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1940 to Aug.13 1945 and that I last saw him alive on Aug.13 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 yrs.

Due to: Gen'l arterio sclerosis — Duration: 5 yrs.

Due to: Heart Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Finkenman M. D.
Address 225 Irondale Rd Date signed Aug 16/45

X

G31597 ✓ G31597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4313 La Salle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4313 La Salle Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Ida Louise C. Soholtholt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife William A.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1890

8. AGE: Years	Months	Days	If less than one day
54	10	25	..... hr. ..... min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Boehler
13. Birthplace Md

MOTHER
14. Maiden Name Mary Rennekamp
15. Birthplace Md

16 (a) Informant Mrs. Wm. A. Soholtholt
(b) Address 4313 La Salle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director L. J. Reyle
(b) Address 5305 Harford Rd

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150 AUG 16 1945 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1945, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to Aug. 14, 1945, and that I last saw he alive on Aug. 14 1945.

Immediate cause of death Coronary Thrombosis — Duration 3 weeks

Due to Coronary Heart Disease — Duration not definitely known

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature A. L. Williams M. D.
Address 5713 Bel Air Rd. Date signed 8-16-45

Balto 6. X

G31598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Myrtle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hopson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9528

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
45 40			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Sawyer
11. Industry or business

FATHER
12. Name John Hopson
13. Birthplace Va

MOTHER
14. Maiden Name Sallie Curtis
15. Birthplace Va

16 (a) Informant John Gordon
(b) Address 807 Colfax way md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16-1945 (month) (day) (year)
(c) Cemetery or crematory Newport News
Location Virginia
18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St
19 (a) AUG 16 1945 (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 8-13-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

631599 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Lincoln Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Colwell J. Colwell 526173

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-1919

8. AGE: Years 26 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name FAIROW. Fairow.
13. Birthplace Ohio

MOTHER
14. Maiden Name G. Rickman
15. Birthplace Ohio

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16 1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St

19 (a) AUG 16 1945 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945, at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1945 to Aug 14 1945, and that I last saw her alive on Aug 14 1945.

Immediate cause of death	Duration
Pulmonary embolism	
Due to pelvic thrombophlebitis	
Due to Suppurative pleurisy with effusion	
Other Conditions	

over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 8-15-45

VS 150

G31600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31600 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Parkhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mabel Anna Bauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: W.

6 (a) ~~Single~~, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband or wife: Jno.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/94

8. AGE: Years 60 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George J. Ulrich

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Semmecher

15. Birthplace Md

16 (a) Informant John Bauer

(b) Address 3314 Parkhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belgian Road

18 (a) Funeral director Lee G. Cook

(b) Address 1901-03 N. Patterson Park Ave

19 (a) (Date filed by registrar) (b) Registrar

AUG 16 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-45 19 , at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24/45 19 to 8/13/45 19 and that I last saw h alive on 8/13/45 19

Immediate cause of death Carcinoma of

Due to Sigmoid colon.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Rodgers M. D.
Address St. Joseph's Hosp. Date signed 8/15/45

X

G31601 ✓ G31601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) na
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmerson C Rohr

3 (b) If veteran, name war yes

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anne L Rohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 — 1890

8. AGE: Years 55 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Burkley Springs W.V.
(town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Self

FATHER
12. Name Rudolph Rohr
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Lewisstown

16 (a) Informant Mrs Anne L Rohr
(b) Address 2906 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-45 (month) (day) (year)

(c) Cemetery or crematory Westwood Cemetery
Location

18 (a) Funeral director Charles O Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

AUG 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15. 1945, at 9.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1944 to Aug 15 1945, and that I last saw h alive on Aug 15 45.

Immediate cause of death Coronary Thrombosis — Duration 1 hour

Due to Arteriosclerotic type heart disease — Duration several years

Due to Generalized arteriosclerosis with hypertension — Duration 4 years

Other Conditions Spastic paralysis Rt leg residual to cerebral hemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.

Address 2901 Edmondson Ave Date signed Aug 15 1945

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Otto John Henry Vey

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Johanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12 1858

8. AGE: Years 87 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business

FATHER
12. Name Henry P. Vey
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa M. Hoffman
15. Birthplace Germany

16 (a) Informant Mrs. Johanna Vey
(b) Address 2411 Edmondson Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

AUG 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1945, at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945, to Aug 14 1945 and that I last saw h m alive on Aug 14 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: July 23-45
Due to: Arteriosclerosis — 4 yrs -
Due to:
Other Conditions: Pulmonary oedema — 1 day
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Lee Thebaut
Address 4116 Northern Parkway Date signed 8/16/45

X

G31603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G31603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3708 Cranston Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Cranston Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTOINETTE RIDLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Clinton L. Ridley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name H. Alden
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mrs. C.L. Ridley
(b) Address 3708 Cranston Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto.

18 (a) Funeral director Mary M. Brinkfield
(b) Address 501 E. Fayette Street

19 (a) (b)

AUG 16 1945 Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14th 1945, at 4 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945, to 8/14 1945 and that I last saw her alive on 8/13 1945

Immediate cause of death: Carcinoma Left Breast (Operated) Generalized Due to Metastases — Duration: 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E Courtenay M. D.

Address 3629 E Lanvale Date signed 8/16/45

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G31604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2827 N Calvert St (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Orem, Elizabeth (Elizabeth E. Orem)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Dr. Fred S. Orem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business —

FATHER 12. Name Herman Conrad

13. Birthplace Baltimore Md. Germany

MOTHER 14. Maiden Name Kinsley Hewitt

15. Birthplace Germany Balto Md

16 (a) Informant Theodora McCreech

(b) Address 1926 Englewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 45 (month) (day) (year)

(c) Cemetery or crematory Green Mt Cem.

Location Greenmount Ave & North ave

18 (a) Funeral director John D. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 8 1945 Huntington Williams M.D. Registrar

(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1945, at 6 49 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10-1945 to 8-15-1945, and that I last saw h[illegible] alive on 8-10-1945.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension and Cerebral Vascular Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. K. Kazeman M. D.

Address Franklin & Howard Date signed 8-16-45

G31605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31605
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 Lemmon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Lemmon ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith S. Scott

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1865

8. AGE: Years	Months	Days	If less than one day
80 79	10	8	22 hr. min.

9. Birthplace Balto Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Bouviter S. Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor E. Goburn
15. Birthplace Del.

16 (a) Informant Gwendolyn G. Scott
(b) Address 236 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Greenmt. & North ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1400 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1945 at 12 30 M A

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moore M.D.
Medical Examiner.
Date signed 8/16/45

Physicians: please write the causes of death clearly and legibly. Cause of death is supremely important.

G31606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G31606

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1913 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bellis

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Florian Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 66 | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Helen Bornschever
(b) Address 219 W. Lorraine Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/16/45 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Rd.

18 (a) Funeral director Wm. W. E. Diggs Sons
(b) Address Lombard & Wanamaker Sts.

AUG 16 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 8-13-45

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Physicians: please write the causes of death clearly and legibly. Be as specific as possible.

G31607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G31607 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3626 Old Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3626 Old Frederick Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William F Cutcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Catherine E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8 1864

8. AGE: Years	Months	Days	If less than one day
80	9	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Frank Cutcher
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Army
15. Birthplace Md

16 (a) Informant Mrs Catherine E Cutcher
(b) Address 3626 Old Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director George E Fahey
(b) Address Fulton & Fayette

19 (a) 8-16-45 (Date received by registrar) (b) Huntington W Thomas, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1945, at 3 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1945 to 8/14 1945 and that I last saw HIM alive on 8/14 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Day
Due to Arteriosclerotic Cardiovascular Disease	5 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E Cochrane

Address 3629 Edmondson Date signed M 8/16/45 D

VS 180

X

631608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

631608
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 517 Stamford (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas W Borelli M.D.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ann Nan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1903

8. AGE: Years	Months	Days	If less than one day
42	1	23½	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Playedcar
11. Industry or business

FATHER
12. Name Wm Borelli
13. Birthplace Italy

MOTHER
14. Maiden Name Virginia Polacco
15. Birthplace Italy

16 (a) Informant Mrs Ann Borelli
(b) Address 517 Stamford Rd

17 (a) Burial (b) Date thereof 8-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Bel Air Md

18 (a) Funeral director Geppi & Stubbs
(b) Address Fulton & Fayette

19 (a) (b)
(Date rec'd by registrar) Registrar

8-20-45 Hunting for Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945, at 2:27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945, to Aug 14 1945, and that I last saw him alive on Aug 14 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cardio-vascular Renal Failure	
Due to Pneumococcemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas Borelli M.D.
Address West Baltimore General Hospital Date signed 8/14/45

X

G31609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31609 ✓ Registered No.

JO #94469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 156 S. Ellwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Brodt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Kellenbeck
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 18 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 S. Orleans St

AUG 17 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945, at 1:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1945, to Aug. 15, 1945 and that I last saw her alive on Aug. 15, 1945.

Immediate cause of death: Multiple Cerebral Hemorrhage — Duration

Due to Heart stroke

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 8-16-45 (M. D.)

VS 150

631610 CHK-77672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111a

✓ 631610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 9- 17
(e) Length of stay in Baltimore (yrs., mos., or days) 75- 6- 21

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Kruepple

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Herbert Kruepple
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24-1870

8. AGE: Years	Months	Days	If less than one day
75	6	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Conrad Killmayer
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer / City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (a) AUG 17 1945 (Date received by local registrar) (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 15 1945 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945, to Aug. 15 1945. and that I last saw h alf alive on Aug. 15 1945.

Immediate cause of death	Duration
[illegible] Pulmonary infarction	
Due to unknown organism	
Due to	
Other Conditions Arteriosclerosis cerebral - paralized (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy Ols above	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Haraland M. D.
Address D.C.H. Date signed 8/16/45

VS 150

X

G31611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G31611 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Cherry Hill Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Collins Senior Collins

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-26-6290

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Ivory

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 - 1915

8. AGE: Years	Months	Days	If less than one day
29	9	21	hr. min.

9. Birthplace Heartsville S. C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Edward Senior.
13. Birthplace S C.

MOTHER 14. Maiden Name Alice Reed
15. Birthplace S C

16 (a) Informant Ivory Senior.
(b) Address 217 Cherry Hill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-45 (month) (day) (year)

(c) Cemetery or crematory
Location Mactee S C.

18 (a) Funeral director Mrs Frances A. Hemby.
(b) Address 578 N Biddle St.

AUG 17 1945 (Date rec'd by local registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15th 1945, at 4 30" P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-45 at 4:30 P. M.
(b) Where did injury occur? Harbor - East of Cherry Hill Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8-16-45.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 631612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2136 N. Howard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mynell Bloodsworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1909

8. AGE: Years 35 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Langford

13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden Name Olivia Lloyd

15. Birthplace Dicomico Co. Md.

16 (a) Informant Marvin Bloodsworth

(b) Address 2136 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16 1945 (month) (day) (year)

(c) Cemetery or crematory Potter's Field Cemetery

Location Somerset Co. Md.

18 (a) Funeral director Mrs. George W. Holland

(b) Address 165 Druid Hill Ave

19 AUG 17 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1945, at 11:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1945 to Aug. 14, 1945; and that I last saw her alive on Aug. 14, 1945

	Duration
Immediate cause of death	
Due to Cardio. Vasc. Renal Disease	4 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2445 D. Hill Ave Date signed 8-16-45

VS 150

631613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1702 Registered No. 631613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm D. Waddell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1917

8. AGE: Years	Months	Days	If less than one day
27	26	8	3 hr. min.

9. Birthplace Rockingham, N.C.
(town, county and state)

10. Usual Occupation Welder

11. Industry or business

FATHER
12. Name William Waddell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Amanda Johnson
15. Birthplace North Carolina

16 (a) Informant William Waddell
(b) Address 522 N. Calvert St.

17 (a) Burial (b) Date thereof Aug. 16, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Family Lot
Location Rockingham, N.C.

18 (a) Funeral director Mrs. Laura A. Allen
(b) Address 1631 Druid Hill Ave
Huntington Williams, M.D.

19 (a) AUG 17 1945
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1945, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Pulmonary artery
Laceration of lung

Due to

Other Conditions Ruptured pulmonary artery, fracture: Laceration, abrasions etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15- at 1:40 P.M.
(b) Where did injury occur? Madison & Mt. Royal
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision between automobiles

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-15-45

VS 151

G31614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G31614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Lillian Elizabeth Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1873

8. AGE: Years 72 | Months - | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Harris
15. Birthplace D. C.

16 (a) Informant Mrs. Rosa L. Butler
(b) Address 1006 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George W. Holland
(b) Address 1631 Druid Hill Ave

19 (a) AUG 17 1945 (Date received by Registrar) (b) Huntingtown, Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Aug 13 1945 and that I last saw h[illegible] alive on Aug 13 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature H. C. Peltelaare M. D.
Address 817 Hamilton Ter Date signed Aug 16/45

M. D. H. 1203-A

ZARZYCKI ✓ G31615

G31615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 134a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 O'Donnell St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 42 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mon. da.

2. FULL NAME John Zarzycki 215-18-3761

(a) Residence: No. 2904 O'Donnell St St., 1-1 Ward.

(Usual place of abode) Md (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Zarzycki

6. DATE OF BIRTH (month, day, year) Oct 8, 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	10	8	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Printer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME ?

14. BIRTHPLACE (city or town) (State or country) ?

MOTHER

15. MAIDEN NAME ?

16. BIRTHPLACE (city or town) (State or country) ?

17. INFORMANT Jennie Zarzycki

(Address) 2904 O'Donnell St.

18. BURIAL, CREMATION, OR REMOVAL

Place Moreland Memorial Date Aug 20 1945

19. UNDERTAKER John J. Duda

(Address) 3824 Hudson St.

AUG 17 1945 19 Huntington Williams, M.D. Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 16, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1944 to Aug. 16, 1945

I last saw him alive on August 13, 1945. Death is said to have occurred on the date stated above, at 7 30 a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Heart paralysis	a few minutes
Alcoholism	Unknown

Other contributory causes of importance:

Kidney Stones	Unknown

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) J. A. Rosenblatt M. D.

(Address) 3018 O'Donnell St. 8-16-45

G31616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31616

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Ave.
(c) Hospital or institution: City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HERBERT SMITH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation unemployed.

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name Ella Chase

15. Birthplace Md.

16 (a) Informant Edith Chase

(b) Address 1556 - Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halstead

(b) Address 918 Druid Hill Ave.

19 (a) 8-17-1945 (Date rec'd by Registrar) (b) Interim for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/45 19 6:00 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to Pulmonary tuberculosis

Other Conditions none

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 8/17/45

VS 151

Cause of death as separately important. Physicians: please write the causes of death clearly and legibly.

C31617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C31617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 North Paulson
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Gilmore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FIGGS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Anna Figgs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1923

8. AGE: Years	Months	Days	If less than one day
21 22	11	26	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Figgs Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Morris
15. Birthplace Md.

16 (a) Informant Mary Morris
(b) Address 313 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 8-17 1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/45 19 , at 1:07 P M

21. I certify that I took charge of the remains described above, held an Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningitis

Due to Fractured Skull

Other Conditions Fractured left radius

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/30/45 M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? (313 N Gilmore) While at work? no
(d) Means of injury Fell out window

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 8/14/45

VS 151

Correct Age is especially important. Physicians: please write the causes of death clearly and legibly.

G31618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G31618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Maryland General Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 26

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3809 Seven Mile Lane

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Daniel O. Rigney

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife A. Irma Rigney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1891

8. AGE: Years	Months	Days	If less than one day
53	8	23	hr. min.

9. Birthplace White Hall Md.

(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business N. George Meade

FATHER

12. Name George L. Rigney

13. Birthplace White Hall Md

MOTHER

14. Maiden Name Lydia L. Hoffman

15. Birthplace Md

16 (a) Informant Mrs. A Irma Rigney

(b) Address 3809 Seven Mile Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-45 (month) (day) (year)

(c) Cemetery or crematory Wiseburg Wiseburg

Location Balto. Co. Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3707 W North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

AUG 17 1945 Huntington

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1945 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1945 to 8/16 1945 and that I last saw him alive on 8/16 1945

Immediate cause of death	Duration
Peritonitis	24 hrs.
Due to Ruptured Sigmoid Diverticulum	28 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Martin E. Hoobler M.D.

Address Md. Gen'l Hospital Date signed 8/16/45

X

Mohlhenrich ✓ G31619

G31619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E. Mohlenrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Alta P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1893

8. AGE: Years	Months	Days	If less than one day
52	1	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business Belt Seed Co

FATHER
12. Name Louis Mohlhenrich
13. Birthplace Md.

MOTHER
14. Maiden Name Lena Griesman
15. Birthplace Md

16 (a) Informant Alta P. Mohlhenrich
(b) Address 1705 W. Lombard St.

17 (a) Burial (b) Date thereof 8/18/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 17 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1945 at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions Fractured Skull 8-23-45 W.J.M.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masseis M.D.
Medical Examiner.
Date signed 8-16-45

VS 151

Cross out words not necessary. Physicians: please write the causes of death clearly and legibly.

G31620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Aull St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Aull Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha E Emery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, ~~or divorced~~
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Allen L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21-1865

8. AGE: Years	Months	Days	If less than one day
79	7	24	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation own Home

11. Industry or business

FATHER
12. Name Unknown Sheeler
13. Birthplace Md

MOTHER
14. Maiden Name Anna Sheeler
15. Birthplace Md

16 (a) Informant Howard Bellman
(b) Address 624 Aull Street

17 (a) Burial (b) Date thereof 8/18/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) 8 17 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1945, at 5:30 P M

21. I certify that I took charge of the remains described above, held an Insp + Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hrs death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
Cerebral Vas. Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Thurston M.D.
Medical Examiner.
Date signed 8/16/45

VS 151

G31621 1145 1890 M

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31621 Registered No.

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie M. Callen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Jesse Callen (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1890

8. AGE: Years 54 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Franklin W. Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Cowger
13. Birthplace Franklin W. Va

MOTHER 14. Maiden Name Mary Heavener
15. Birthplace Franklin W Va.

16 (a) Informant Jesse Callen
(b) Address 1702 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 45 (month) (day) (year)
(c) Cemetery or crematory Morland Mem Park
Location Balto, Md.

18 (a) Funeral director D. L. Covington
(b) Address 21 W 25 St.

19 (a) 8-17-1945 (Date rec'd by registrar) (b) Huntington, Williamson W Va Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1945 to 8-15 1945 and that I last saw h[illegible] alive on 8-15 1945.

Immediate cause of death Myocardial degeneration — Duration 6 days
Due to Acute Glomerular
Due to Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Miller M. D.
Address 410 N Bdwy Date signed 8/17/45

X

G31622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G31622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 E. Chase St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Joan Smith

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1934

8. AGE: Years	Months	Days	If less than one day
10 yrs.	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name Frederick Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Warneke
15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Smith
(b) Address 2325 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/45 (month) (day) (year)
(c) Cemetery or crematory Schunks
Location O'Donnell St

18 (a) Funeral director Clarence T. Hoffman
(b) Address 1637 N. Broadway

19 (a) (Date rec'd by registrar) AUG 17 1945 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1945, at 4:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945, to Aug 15 1945, and that I last saw her alive on Aug 15 1945.

	Duration
Immediate cause of death: Cardiac failure	2 days
Due to: Diphtheritic myocarditis	10 days.
Due to: Kleb-Loeffler bacillus	
Other Conditions: Tracheotomy	7 days.

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron S. Lee M. D.
Address Sydenham Hosp Date signed

correct age is especially important. If uncertain, please write "about" before the number. Do not guess.

631623

BALTIMORE CITY HEALTH DEPARTMENT ✓ 631623

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 E. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Pabst Corbett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/1889

8. AGE: Years	Months	Days	If less than one day
56	5	19	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name CHARLES. F. PABST
13. Birthplace GERMANY

MOTHER 14. Maiden Name ELIZABETH ALTEVOGT
15. Birthplace BALTIMORE MD

16 (a) Informant John E Corbett
(b) Address 1701 E Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Clarence F Hoffman
(b) Address 1639 N Broadway Huntington Williams, M.D.

19 (a) AUG 17 1945 (Date rec'd by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1945 at 8.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Sub-dural and intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-15-45

VS 151

X

G31624

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31624 Registered No. 3698

CERTIFICATE OF DEATH 939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Baltimore City
(b) Street address 1037 N Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

16-2

3 (a) FULL NAME Cleo Plowden Wineberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	Widowed

6 (b) Name of husband or wife Alexander Wineberry
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) July ? 1893

8. AGE: Years	Months	Days	If less than one day
52	1		hr. ——— min.

9. Birthplace Frederick md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business Own home

FATHER
12. Name Unknown
13. Birthplace Frederick Co md

MOTHER
14. Maiden Name Pinkie Brown
15. Birthplace Frederick Co md

16 (a) Informant Mary Nelson
(b) Address 2341 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Kelly
(b) Address 1303 Pennsylvania Ave

19 (a) ——— (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

AUG 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1945 to Aug. 17 1945. and that I last saw her alive on 8-13-1945

Immediate cause of death	Duration
Myocarditis	Unknown
Due to	
Due to	
Other Conditions Arteriosclerosis and hypertension	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 8-15-45

X

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

G31625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6004 Falls Road
(c) Hospital or institution:

27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6004 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William P. Chalk, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marguerite V. Chalk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20. 1883

8. AGE: Years 62 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Mt. Washington, Md. (Town, county, and state)

10. Usual Occupation Mail carrier

11. Industry or business

FATHER
12. Name Bennett P. Chalk
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth Ann Elizabeth Hildebrandt
15. Birthplace Maryland

16 (a) Informant Mrs. Marguerite V. Chalk
(b) Address 6004 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date received by local registrar) (b) Registrar

AUG 17 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15. 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1945, to 8-15 1945. and that I last saw h. l. alive on 8-14 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage.	55 hrs
Due to Hypertensive CVD	2
Due to	
Other Conditions Parkinsons Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. **Signature** Lawrence J. Shimanek M. D.
Address 2711 Falls Rd Date signed 8-16-45

SHIMANEK

150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31626 (Col.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5½ months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

20274

3 (a) FULL NAME Joseph Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-45 March 7, 1945

8. AGE: Years	Months	Days	If less than one day
—	5	9/14	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Joseph H. Monroe
13. Birthplace Richmond Co, Va.

MOTHER
14. Maiden Name Nellie Green.
15. Birthplace Calvert Co., Md.

16 (a) Informant Nellie Green
(b) Address 1107 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St

19 AUG 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 19 45 at 7:10 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 19 45 to Aug 16 19 45 and that I last saw him alive on 8-16 19 45

Immediate cause of death	Duration
Acidosis	
Due to dehydration	
Due to diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Robinson M. D.
Address Univ. Hosp. Date signed 8-16-45

VS 150

X

G31627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. Fremont Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jennie Mitchell Spriggs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	widowed

6 (b) Name of husband or wife Peter Spriggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	21	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Mitchell
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Virginia Taylor
15. Birthplace Baltimore, Md

16 (a) Informant Ella Tate (daughter)
(b) Address 539 N. Fremont.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Lafayette St.

19 (a) AUG 17 1945 (Date rec'd by registrar) (b) Lafayette Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 August 1945, at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 June 1945, to 14 Aug 1945, and that I last saw h[illegible] alive on 13 Aug 1945.

Immediate cause of death	Duration
Hypertensive heart Disease	6.11.45
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James M. Pair
Address 400 N Lanvelton Ave Date signed M. 8. D. 16. 45

James E. X Pair

VS 3

631628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 631628

631628

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 857 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State M (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 857 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Robinson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Augustus
15. Birthplace Baltimore Md.

16 (a) Informant Yourtee Robinson
(b) Address 857 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 3985 N Schroeder St.

19 (a) AUG 17 1945 (Date rec'd by registrar) (b) Huntington Wilkins

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1945 at 2:30 P M

21. I certify that death occurred on the date above stated that I attended deceased from Aug 1 1945 to Aug 15 1945.
and that I last saw h[illegible] alive on Aug 15 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 8/17/45

VS 180

G31629 Gershen Beichman ✓ G31629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gershen Beichman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, state)
10. Usual Occupation Pants Mfg
11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Meyer Beichman
(b) Address 2533 Brookfield Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location Georgetown Hall Road
18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Baltimore St Huntington Williamsport, Md
19 (a) Date received by registrar 8-17-1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1945, at 8:15 AM

21. I certify that death occurred on the date above stated: that I attended deceased from 8-17 1943 to 8-17 1945 and that I last saw him alive on 8-17 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension & Arteriosclerosis	
Due to	
Other Conditions Hypertension cardiovascular renal disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L Rosenthal M. D.
Address Sinai Hospital Date signed 8-17-45

VS 150

X

G31630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1420

~~G31630~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 541 N. Mount St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Louise Williams

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert

6 (c) If alive, give age: 24 years

7. Birth date of deceased (mo., day, yr.) June 28, 1922

8. AGE: Years 23 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace Allenton S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lindsay Wright
13. Birthplace Allenton S. C.

MOTHER
14. Maiden Name Pearl [illegible]
15. Birthplace S. C.

16 (a) Informant Robert Williams (H.)
(b) Address 541 N. Mount St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/19/45 (month) (day) (year)
(c) Cemetery or crematory Dunbar
Location Allenton S. C.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 Carrollton Ave.

18 (a) Date received by registrar 8-17-1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945, at 7:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to
extra-uterine pregnancy
~~Due to~~ Tubal rupture.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Heaver M.D. Medical Examiner.
Date signed 8-16-45

VS 151

G31631

JO #95293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30 F

G31631 Registered No. (w)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
4940 Eastern Avenue 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Greene St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Wilson G 13697

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1944.

8. AGE: Years	Months	Days	If less than one day
---	8-11	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Glenn O. Wilson
13. Birthplace West Virginia

MOTHER
14. Maiden Name Phyllis Ice
15. Birthplace West Virginia

16 (a) Informant Records, Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/45 (month) (day) (year)
(c) Cemetery or crematory Parkesburg
Location W. Virginia

18 (a) Funeral director Geo. J. Fackler & Sons
(b) Address Baltimore, Md.

19 (a) 1945 (Date rec'd by registrar) (b) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at 6:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1945, to Aug. 17 1945, and that I last saw her alive on Aug. 16, 1945.

Immediate cause of death	Duration
Impetigo Contagiosum Bullosum	10 days
Due to	
Due to	
Other Conditions Diarrhea Congenital Syphilis Rx (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. Baysetti
Address John E. Baysetti Date signed 8/17/45 M. D.
Balt. City Hosp. 153

VS 150

Page is especially important. Physicians: please write the causes of death clearly and legibly.

G31632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 N. Rose
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Rose 10 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wittich

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 214-03-0882

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances Gontowski Wittich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1889

8. AGE: Years 56 | Months 4 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Hoist Master

11. Industry or business Iron Co.

FATHER
12. Name Charles Wittich
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Loose
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Frances Wittich
(b) Address 124 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cemetery
Location 5501 Frederick Rd

18 (a) Funeral director Elmer W. Conkling Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

AUG 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15, 1945 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19th 1945, to Aug 15th 1945, and that I last saw h[illegible] alive on Aug 15th 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	one month
Due to Arteriosclerosis & Hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Tuttle M. D.
Address 100 N. Mullowny Date signed 8/17/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31633 Registered No. 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Redwood Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 18a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Daniels
(If outside city or town limits, write RURAL and give town)
(d) Street No. Guilford
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Acquilla Martin

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1944

8. AGE: Years | Months: 11 | Days: 7 | If less than one day: hr. min.

9. Birthplace Laurel, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name McKenley Martin
13. Birthplace North Carolina

MOTHER
14. Maiden Name Dorothy Cornwell
15. Birthplace Randallstown, Md.

16 (a) Informant Mrs Dorothy Martin
(b) Address Daniels, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/45 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd
Location Howard Co. Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) (Signature of registrar) (b) Registrar

AUG 17 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1945 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13, 1945 to Aug 17 1945, and that I last saw him alive on Aug 17 1945.

	Duration
Immediate cause of death Acidosis	
Due to Dehydration	
Due to Diarrhea	
Other Conditions Myasthenia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Clark, Jr. M. D.
Address Univ. Hosp. Balto. Date signed 8/17/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31634

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 93D

G31634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Fulton Ave.
(c) Hospital or institution: Mercy Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ETHEL CAREY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Robert Carey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1899

8. AGE: Years	Months	Days	If less than one day
46	0	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Samuel W. Harvey
	13. Birthplace Virginia
MOTHER	14. Maiden Name Mary Catherine Crowley
	15. Birthplace Virginia

16 (a) Informant Clinton Carey
(b) Address 22 S. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co. Md.

18 (a) Funeral director Williams Cooke, Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar Williams M.D.

AUG 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 15, 1945 to August 17, 1945, and that I last saw h-e alive on August 17, 1945.

Immediate cause of death	Duration
Acute pulmonary edema	2 days
Due to Hypertensive cardio-vascular disease	several years?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David T. Bell, Jr. M.D.
Address Mercy Hospital Date signed 8/17/45

X

BHD File No. 94875 631635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

631635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
6 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Joplin Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward C. Vickery
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 18, 1886

8. AGE: Years	Months	Days	If less than one day
58	9	29	hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Contracting Painter
11. Industry or business Self

FATHER
12. Name John Vickery (D)
13. Birthplace Tenn.

MOTHER
14. Maiden Name Dorothy Wise (D)
15. Birthplace Tenn.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or crematory Lexington
Location Kentucky
18 (a) Funeral director William Cook Inc
(b) Address 127 E. Pratt St Huntington West Virginia
19 (a) Date received (b) Registrar

AUG 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945 at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1945, to Aug. 17, 1945, and that I last saw him alive on Aug. 17, 1945.

Immediate cause of death	Duration
Cardiac failure	7
Due to arteriosclerotic heart disease	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 8-17-45

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G31636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G31636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 E. 31st st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. 31st st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Matilda Volk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) May 16th 1896

8. AGE: Years 49 | Months 4 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O R.R.

FATHER
12. Name Joseph N. Volk
13. Birthplace Md.

MOTHER
14. Maiden Name Emma R. Hayward
15. Birthplace Md.

16 (a) Informant William E. Volk
(b) Address 1813 E. 31st St

17 (a) Burial (b) Date thereof 8/18/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) ~~Cemetery or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 8-18-1945 (Huntington Williams, M.D.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1945, at 10:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945, to Aug 15 1945 and that I last saw h[illegible] alive on Aug 15 1945.

Immediate cause of death Carcinoma of Ovary — Duration 6 mo

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation June Aug 7 45

Major findings of operation: carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. T. Long M.D.
Address 622 N. Paca Date signed 8/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31637 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 N. Calvert st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 N. Calvert st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston M. Gardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Mabel Putts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11th 1881

8. AGE: Years	Months	Days	If less than one day
64	7	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Partner
11. Industry or business Henry Keidel Co.

FATHER
12. Name William Gardner
13. Birthplace Germany

MOTHER
14. Maiden Name Kate M. Mosher
15. Birthplace Md.

16 (a) Informant Mabel P. Gardner
(b) Address 2908 N. Calvert St.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) AUG 18 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15th 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Aug 15 1945 and that I last saw him alive on Aug 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Unknown
Due to Coronary Sclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. R. Gardner M.D.
Address 2923 St Paul St Date signed 8/17/45

X

VS 150

631638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

Registered No. 631638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 N. Bond Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex Male | Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 18 1945 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945 at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Woodward M.D.
Medical Examiner.
Date signed 8-17-45

2902 Howard L. Haslett, M.D.

VS 151

G31639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Wilbert Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name	Joseph Holloway
FATHER — 13. Birthplace	Va.
MOTHER — 14. Maiden Name	Emaline
MOTHER — 15. Birthplace	Va.

16 (a) Informant Wilbert Jackson
(b) Address 17 N. Spring St.

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Aug 18 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calv.
Location Brookland Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pleasant Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1945, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Pulmonary Tuberculosis with cavitation.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard L. Warren M.D. Medical Examiner.
Date signed 8-17-45

X

G31640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 Eutaw Place (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosina C. Joseph

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
59	2	24		

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business

FATHER
12. Name Philip Joseph,
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Cobletz
15. Birthplace Balto. Md.

16 (a) Informant Mrs. D. C. Joseph,
(b) Address 1513 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Sonnheim & Son
(b) Address 1902 Eutaw Place

19 (a) AUG 18 1945 (Date received by registrar)
Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 - 1945, at 10:13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 - 1945 to Aug. 17 1945, and that I last saw her alive on Aug. 17 - 1945.

Immediate cause of death	Duration
Coronary Insufficiency	
Due to	
Due to	
Other Conditions Pulmonary Infarction, Hemothorax	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jaffe M. D.
Address 1700 Eutaw Place Date signed Aug. 17-45

VS 180

X

The correct age is especially important. Physicians: please write the cause of death clearly and legibly. Every item of information should be carefully supplied.

G31641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31641 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1700 E Monument St

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2134 Pressman st (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Simon J Ballan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W,

6 (b) Name of husband or wife Late Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 5, 1894

8. AGE: Years	Months	Days	If less than one day
50	10	11	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Liquor Merchant

FATHER 12. Name Michael Ballan

13. Birthplace Russia

MOTHER 14. Maiden Name Cherna Rotganz

15. Birthplace Russia

16 (a) Informant Philip Schweitzer

(b) Address 1923 N Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19, 1945 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men Cem

Location Windsor Mill Road

18 (a) Funeral director Bob Levinson & Bros

(b) Address 1124-26 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS AUG 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1945 to 8-16 1945, and that I last saw h alive on 8-16 1945.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Coronary Infarction	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John L Rosenthal M. D.

Address Sinai Hospital Date signed 8-16-45

Huntington for Baltimore, Md.

X

G31642

CHK-94155

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

G31642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 2- 1
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace McLaurin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31-1901

8. AGE: Years 44 Months 6 Days 13/14 If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McLaurin
13. Birthplace N. C.

MOTHER
14. Maiden Name Daisy Smith
15. Birthplace N. C.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Jno. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (Date received by Registrar) AUG 18 1945 Lantzington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to Aug. 14 1945, and that I last saw him alive on Aug. 14 1945.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	2
Due to: Intestinal Tuberculosis	
Due to:	
Other Conditions: Amyloidosis and Bedsores	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Eastland Jr. M. D.
Address Balto. City Hosp. Date signed 8/16/45

correct age is especially important. Physicians: please write the causes of death clearly and legi

VS 150

G31643 ✓ G31643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 89a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Gouge Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George John Polyeis (SALYERS.) ✓
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 29-39
8. AGE: Years 5 | Months 9 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesse W. Polyeis
13. Birthplace Md

MOTHER
14. Maiden Name Mildred McDonough
15. Birthplace Md.

16 (a) Informant Records - JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-45 (month) (day) (year)
(c) Cemetery or Crematory Holy Cross
Location Gov Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover 8-25

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1945 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1945 to 8-16 1945, and that I last saw him alive on 8-16-45 at 11.50 AM.

Immediate cause of death Respiratory failure — Duration 11 days.

Due to Brain abscess
otitis media

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: Cerebellar abscess; otitis media

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Yound M. D.
Address Johns Hopkins Hosp Date signed 8-16-45

X

Please write plainly, with INDELIBLE INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. G31644

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giovanni or John Giustina

3 (b) If veteran, name war: none

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maria Giustina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1885

8. AGE: Years 60 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Grinding Service

11. Industry or business

FATHER
12. Name Santo Giustina
13. Birthplace Italy

MOTHER
14. Maiden Name Caterina Mosca
15. Birthplace Italy

16 (a) Informant Maria Giustina (Wife)
(b) Address 222 S. Conkling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 20th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) Registrar

AUG 18 1945 Huntington Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-45 19 , at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-45 19 to 8-17-45 19 , and that I last saw h alive on 8-17-45 19

Immediate cause of death: Bronchogenic Carcinoma of L Lung

Due to

Due to

Other Conditions Chronic Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.

Address 222 S. Conkling Date signed 8-18-45

X

G31645 RATHER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G31645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 E 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Hamilton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Edward Rather

3 (b) If veteran, name war: None ?

3 (c) Social Security Account No. 212-09-1692

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs. Francis Rather

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 15, 1884

8. AGE: Years 61 | Months 4 | Days 2 | If less than one day: XXXX hr. XXXXXX min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Manufacturer Iron

FATHER
12. Name Charles Rather
13. Birthplace Germany

MOTHER
14. Maiden Name ? ? Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Frances Rather
(b) Address 2606 Hamilton Ave. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory Oak Bluff
Location Annapolis Md

18 (a) Funeral director William J. Buckner & Sons
(b) Address Forest & Pennsylvania Aves

19 AUG 18 1945 (Date received by registrar) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/45 19 , at 11:10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 19 45, to 8/17 19 45, and that I last saw him alive on 8/17 19 45.

Immediate cause of death: Transaction at Spinal Cord & Tz (Thoracic Three)

Duration: 24 hrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8/16/45 at 11:00 A. M.
(c) Where did injury occur? Balt. (City or town) Balt. (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell from Second Story Porch

23. Signature Harold H. Merriman Jr.
Address Union Memorial Hospital Date signed 8/18/45

Howard J. Clemens M.D.

Instructions: Every item on this certificate should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

Registered No. 631646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Frederick Satterfield

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-10-2204

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie A. Satterfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15th 1872

8. AGE: Years 73 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John F. Satterfield
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Satterfield
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William M. Satterfield (SON)
(b) Address 1917 Cecail Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 20-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) Date received AUG 18 1945 (b) Filed Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16- 1945, at 6 40 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Compound Fracture by bones.

Due to

Other Conditions Pulmonary Tuberculosis
Fractured humerus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23

(a) Date of injury 10:45 P.M. July 28, 1945
(b) Where did injury occur? Cromwell & Hanover
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Struck by and while alight- ing from street car

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8-17-45

G31647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G31647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 441 E. 22nd St. Balto. 18 Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Campbell (Blanche Agnes Campbell)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ross Philip Campbell Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1888

8. AGE: Years 56 | Months 11 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Prince Georges Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Oliver Wickham
13. Birthplace Md.

MOTHER
14. Maiden Name Clementine Harvey
15. Birthplace Md.

16 (a) Informant Mr. Ross P. Campbell, Jr.
(b) Address 441 E. 22nd St. Balto 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc
(b) Address North & Pa. Aves.

19 (a) ... (Date received by registrar) (b) Huntington Williams, M.D. Address

AUG 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1945 at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1945 to 8/17 1945 and that I last saw her alive on 8/12 1945

	Duration
Immediate cause of death Acute Pulmonary edema, and Cardiac Failure	6 hrs.
Due to Bronchogenic Carcinoma T metastasis to Brain.	?
Due to Hypertension Cardio-Vascular Renal Disease.	7 years
Other Conditions Cardiac Enlargement. Rt. Pleural Effusion	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D. Clark M.D.
Address Univ. Hosp. Date signed 8-17-45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160 C

Registered No. G31648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, 24, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Niemczyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/45

8. AGE: Years	Months	Days	If less than one day
			19 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Melvin Anthony Niemczyk
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lela Mary Branding
15. Birthplace Baltimore, Md.

16 (a) Informant Father
(b) Address 1219 S. Decker Ave.

17 (a) Burial (b) Date thereof 8-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann st

19 AUG 18 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17, 1945, to Aug. 17, 1945, and that I last saw h i m alive on Aug. 17, 1945.

Immediate cause of death	Duration
Atelectasis	
Due to Aspirated amniotic fluid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Riley M.D.
Address 1400 N. Caroline St. Date signed 8/18/45

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G31649

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Raymond Berry

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-5916

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Zelma Berry
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 27, 1887

8. AGE: Years 58 | Months 4 | Days 20 | If less than one day ? hr. ? min.

9. Birthplace Frankton, Ind.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Wm. Berry
13. Birthplace Not known

MOTHER
14. Maiden Name Not known. Pugh
15. Birthplace Not known

16 (a) Informant Mrs. Zelma Berry
(b) Address 2904 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Lorraine
Location Woodlawn Md

18 (a) Funeral director Ellis S. White
(b) Address 2840 Cold Spring Lane

19 AUG 18 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1945, at 12 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1945, to Aug 17 1945, and that I last saw him alive on Aug 17 1945

Immediate cause of death	Duration
Toxemia	
Due to Cancer of the Rectum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. B. Barney M. D.
Address University Hosp. Date signed 8-17-45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G31650

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3000 Darby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estella Burke.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 7 1877

8. AGE: Years	Months	Days	If less than one day
67	8	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Leonard Burke
13. Birthplace Maryland.

MOTHER
14. Maiden Name Carp Shipley
15. Birthplace Maryland.

16 (a) Informant Mrs. Edna M. Collins
(b) Address 3000 Darby St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chadwick & Donovan
(b) Address 361 5-17 Chestnut Ave

19 (a) Filed (Registrar) AUG 18 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1945 at 1 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 27 1945 to Aug 16th 1945 and that I last saw h-- alive on Aug 14th 1945.

Immediate cause of death	Duration
Intestinal Torsion	
Due to obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Friend M. D.
Address 361 Fairmount Blvd Date signed 8/16/45

VS 150

X

31651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93a

Registered No. G31651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5514 Mattfeldt Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5514 Mattfeldt Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenza Wolfenden

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married.

6 (b) Name of husband or wife Allen Wolfenden
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1904

8. AGE: Years	Months	Days	If less than one day
40	9	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John P. Eccard
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Main
15. Birthplace Maryland

16 (a) Informant J. Allen Wolfenden
(b) Address 5514 Mattfeldt Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Randallstown Md

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) AUG 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1945, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1944 to Aug 16th 1945, and that I last saw her alive on Aug 16th 1945.

Immediate cause of death Coronary Thrombosis Duration 5 Hours

Due to Hardening of the Arteries

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Lillich M.D.
Address 311 Forest Ave. Balto Date signed 8/16/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G31652

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 423 N. Central Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 423 N. Central Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Carolyn Bessie Washington

3 (b) If veteran, name war

Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-45

8. AGE: Years	Months	Days	If less than one day
	4	15	hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Lorenzo Washington

13. Birthplace Va

MOTHER

14. Maiden Name Rosalie Bruce

15. Birthplace S. C.

16 (a) Informant Rosalie Washington

(b) Address 423 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto County Md.

18 (a) Funeral director Robert L. Young

(b) Address 804 N. Carrollton St

19 (a) AUG 18 1945 (b) Huntingtor Williams, M.D.

Aug. 17, 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Aug 16 1945 and that I last saw her alive on Aug 14 1945.

Immediate cause of death	Duration
Acute myocarditis	
Due to (a) Acute Bronchitis	
(b) Influenza	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert C. Barnwell

Address 121 Augusta Date signed 8/16/45 M. D.

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

Registered No. G31653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie J. Chamberlain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Married

6 (b) Name of husband or wife Wm. E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1905

8. AGE: Years	Months	Days	If less than one day
40	7	14	hr. min.

9. Birthplace Md
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Holland
13. Birthplace Md.

MOTHER
14. Maiden Name Lucie Bentley
15. Birthplace Md.

16 (a) Informant Wm. E. Chamberlain
(b) Address 1825 Ashland Ave

17 (a) Burial (b) Date thereof 8/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Robert L. Young
(b) Address 804 N. Caroline St
AUG 18 1945 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Aug 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1945, to Aug 17 1945, and that I last saw her alive on Aug 17 1945.

Immediate cause of death	Duration
Acute respiratory Failure	
Due to Chronic Pulmonary Tuberculosis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert E. Brunwald M.D.
Address 171 Eighth Date signed 8/17/45

X

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31654 / 1648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maine (b) County
(c) City or town Portland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Brackett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar C. [redacted] Seabury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Evelyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1896

8. AGE: Years 49 | Months 1 | Days 2 | If less than one day: hr. min.

9. Birthplace Falmouth, Maine
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business Merchant Marine

FATHER
12. Name Benj. F. Seabury
13. Birthplace Chebeague, Maine

MOTHER
14. Maiden Name Lucy J. Kennedy
15. Birthplace Chebeague, Maine

16 (a) Informant Mrs. Evelyn Seabury
(b) Address 325 Brackett St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/18/45 (month) (day) (year)
(c) Cemetery or crematory Forest City Cem.
Location South Portland, Maine

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Ave.,

19 AUG 18 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at 7 05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-45 at 7 P. M. 14
(b) Where did injury occur? Ft. of Kennard Ave Portland
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes.
(d) Means of injury Found drowned.

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 8-19-45

VS 151

G31655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G31655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ellen Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife Feb. 11, 1856
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
89	6	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Rogers Tuttle
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-45 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City Md

18 (a) Funeral director J. C. Herring & Son
(b) Address Ellicott City Md

19 (a) AUG 19 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16- 1945, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8-45 1945 to 8-16- 1945, and that I last saw her alive on 8-16- 1945.

Immediate cause of death Myocarditis
Due to Adv. arteriosclerosis
Due to
Other Conditions Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacobs M. D.
Address 1700 Eutaw Pl Date signed 8-16-45

VS 3

G31656

BALTIMORE CITY HEALTH DEPARTMENT ✓ G31656 Registered No.

CERTIFICATE OF DEATH 13/a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Haywood ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Haywood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Eppers

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Jane Eppers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 - ~~1866~~ 1867

8. AGE: Years	Months	Days	If less than one day
78 ~~79~~	7	15	hr. min.

9. Birthplace Baltimore Co Md
(Town, county, and state)
10. Usual Occupation Pattern Maker
11. Industry or business Cabinet Making

FATHER
12. Name John Henry Eppers
13. Birthplace Eckenford - Denmark

MOTHER
14. Maiden Name Bettie G. Osa
15. Birthplace Hanover, Germany

16 (a) Informant Roland S. Crowther
(b) Address 3510 Haywood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 - 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Loomis Byers
(b) Address 605 Park Heights ave

19 (a) (Date received by Registrar) (b) Registrar

AUG 19 1945

Furniture for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1945, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Many years to Aug 16 1945, and that I last saw him alive on Aug 16 1945.

Immediate cause of death	Duration
Pneumonia	3 days
Due to Nephritis - Cystitis	?
Due to Arterio Sclerosis	?
Other Conditions Chronic Prostatitis 4 - 5 yrs	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Nichols M.D.
Address Pikesville Md Date signed 8/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

(over)

X

2490 G31657 BALTIMORE CITY HEALTH DEPARTMENT ✓G31657
Registered No.

CERTIFICATE OF DEATH 134a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Chester (If outside city or town limits, write RURAL and give town)
(d) Street No. 2317 Madison Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lerman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) - 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
(c) Cemetery or crematory Brookhaven
Location Brookhaven Pa

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1459 E Baltimore St

AUG 19 1945 (Date rec'd by registrar) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1945 to Aug 18 1945 and that I last saw him alive on Aug 18 1945

Immediate cause of death: Septicemia (Contractor) — Duration: 10 days
Due to
Due to
Other Conditions Myelofibrosis, Varicose Ulcer Rupture
(Include pregnancy within 3 months of death)
Date of operation 5/14/45 (Prof. Adm.)
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Johns Hopkins Hosp Date signed 8/19/45

VS 150

copy is especially important. Physicians: please write the causes of death clearly and legibly.

G31658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G31658

166

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turner's Station (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 59 | Months | Days | If less than one day hr. min.

9. Birthplace Blanche N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Spencer Jefferson
13. Birthplace N. C.

MOTHER
14. Maiden Name Jeanette Long
15. Birthplace N. C.

16 (a) Informant John Jefferson
(b) Address 207 Sollers Pt. Rd. Stapleton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-45 (month) (day) (year)

(c) Cemetery or crematory
Location Blanche N. C.

18 (a) Funeral director Sam'l W. Chase Son
(b) Address 638 N. Eutaw St

16 (a) 19 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1945 at 5:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
acute diffuse peritonitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-10-45 at 9:10 A. M. 3/8
(b) Where did injury occur? 4th Floor Va.-Md. Fuel Co. Eastern Ave. & President Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms.

23. Signature Howard J. Conners M.D.
Medical Examiner.
Date signed 8-16-45

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G31659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31659

Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Pl.
(c) Hospital or institution: Elmhurst Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4503 Maple ave Halethorpe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Lanman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife George W. Lanman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1862

8. AGE: Years	Months	Days	If less than one day
83	-	14	hr. min.

9. Birthplace Dallas, Ill.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Absalom Buchanan
13. Birthplace Pa.

MOTHER
14. Maiden Name Martha Bush
15. Birthplace Indiana

16 (a) Informant Mr. Claude C. Lanman
(b) Address 4503 Maple Ave. Halethorpe

17 (a) Burial (b) Date thereof 8-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Montevallo
Location

18 (a) Funeral director Fred A. Cole
(b) Address 1 Main Longboard St Huntington Williams Md.

19 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Aug 18 1945, and that I last saw h alive on Aug 18 1945.

Immediate cause of death	Duration
Chronic Myocarditis	9 yr.
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Parran
Address Halethorpe Md. Date signed 8/18/45

VS 150

X

co ct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31660 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1253 Pulliam St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Pulliam
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Irene Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife William Walter Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/24/1881

8. AGE	Years	Months	Days	If less than one day
	63	10	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Martin V. Rudolph
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Noone
15. Birthplace Baltimore

16 (a) Informant Mrs. W. H. Phillips
(b) Address 1253 Pulliam

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Stephen Hayes
(b) Address [illegible]

19 1945 (a) (b) Registrar
(Date filed by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/ 1945, to 8/16/ 1945, and that I last saw her alive on 8/16/ 1945.

Immediate cause of death Lobar pneumonia — Duration 5 days

Due to

Due to

Other Conditions Hypertensive cardio vascular disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deiler M. D.
Address 1226 Hanover St. Date signed 8/18/ 1945.

Except age is especially important. Physicians: please write the causes of death clearly and legibly.

G31661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

G31661
Registered No.

Date is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3415 Leverton Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Leverton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Savage

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife David GL Savage
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) March 30, 1885

8. AGE: Years	Months	Days	If less than one day
60	4	16	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Alois Baummar
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Mrs Gertrude Urie
(b) Address 707 S. Bouldin St.,

17 (a) Burial (b) Date thereof Aug 20 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) Huntington Williams, Registrar
(Date rec'd by registrar) AUG 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1945 at 12 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945, to Aug 16 1945, and that I last saw h alive on Aug 15 1945.

Immediate cause of death	Duration
TRANSVERSE Carcinoma of Transverse Colon with liver metastasis	Apx 1 yr
Due to	
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Schumacher M. D.
Address 842 S East Ave Date signed 8-16-45

SCHUMACHER

VS 150

G31662 CERTIFICATE CORRECTED 11-21-50 G31662

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH V 170C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3403 Clifmont Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Clifmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. P. Wagner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sophia Wagner
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Aug 23 1887
8. AGE: Years 54 | Months 11 | Days 25 | Less than one day ____ hr. ____ min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Gen Supt
11. Industry or business Revere Copper Wks

FATHER
12. Name Conrad Wagner
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine Jupp
15. Birthplace Balto

16 (a) Informant Sophia Wagner
(b) Address 3403 Clifmont Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2108 Allendale St
19 (a) 8-19-1945 (Date filed by registrar) (b)
Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945 at 9 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Sinai death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest, Ruptured heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9 P.M 8-17-45
(b) Where did injury occur? Chase & Wolfe Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto into parked Army trailer

23. Signature Howard J. Weiss M.D.
Medical Examiner.
Date signed 8-18-45

VS 151

G31663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31663 Registered No.

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly. Type correct age is especially important. Please answer all questions. Entries must be carefully supplied. Typ

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 309 Gwynn Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 309 Gwynn Avenue

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Leon J. Bena

3 (b) If veteran, name war No

3 (c) Social Security Account No. Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1903

8. AGE: Years	Months	Days	If less than one day
41	9	22	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Emile J. Bena

13. Birthplace France

MOTHER

14. Maiden Name Augustne Bulanger

15. Birthplace France

16 (a) Informant Mrs. Mary M. Bena

(b) Address 309 Gwynn Avenue

17 (a) Burial (b) Date thereof 8/21/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Avenue

18 (a) Funeral director Edward Toulson

(b) Address 2359 Washington Blvd.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1945 to Aug. 17 1945, and that I last saw him alive on Aug. 17, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	30 hrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature George A. Kupp M.D.

Address 3030 Edmondson Ave. Date signed 8/19/45

VS 150

G31664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓123

G31664 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline ave.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 610 S. Ellwood Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mary C. Dunnigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/8/32

8. AGE: Years	Months	Days	If less than one day
13	3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER

12. Name Joseph L. Dunnigan

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Honza Mackessy

15. Birthplace Balto. Md.

16 (a) Informant Joseph L. Dunnigan

(b) Address 610 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21-45 (month) (day) (year)

(c) Cemetery or crematory New Cath.

Location Old Frederick Rd.

18 (a) Funeral director John A. Hannon

(b) Address 3600 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-45 19 7.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10/45 19 to 8/17/45 19 and that I last saw her alive on 8/17/45 19

Immediate cause of death	Duration
Septemia	
Due to Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pinguecula sclera

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. M. R. Rawlings M. D.

Address St. Joseph's Hospital Date signed 8-17-45

AUG 18 1945

Dr. Carozza
York Road.

G31665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Barclay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORBERT B. DUNN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59	-	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Consulting Engineer
11. Industry or business Contractor

FATHER
12. Name Jos. B. Dunn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Ann Kelly
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. N.B.Dunn
(b) Address 2207 Barclay Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto.

18 (a) Funeral director Mary M. Heidsfield
(b) Address 550 East 6[illegible] St

19 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th 1945, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6 1944 to 8-17 1945, and that I last saw h/M alive on 8-16 1945.

Immediate cause of death
Cerebral Hemorrhage.
Angina Pectoris.
Due to Cardio Vascular disease

Duration
1 Mo.
1 yr.
1 yr.

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. Carozza
Address 5211 York Rd. Date signed 8/18/45

X

G31666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 S. CONKLING ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days) 30 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 S. CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA WAECHTER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOHN O. WAECHTER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 1 1887

8. AGE: Years 58 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace MT. SAVAGE MD.
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name EDWARD WILLS
13. Birthplace MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace MD.

16 (a) Informant JOHN WAECHTER (SON)
(b) Address 1002 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zerbe Co.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) 19 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 17 1945, at 6/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to Aug 17 1945
and that I last saw Rose alive on Aug 7 1945

Immediate cause of death	Duration
Diabetes Mellitus	1-2-44
Arteriosclerotic C-V Disease	1-2-44
Due to Coronary Sclerosis	6-15-45
Coronary Occlusion	8-17-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 842 S. East Ave Date signed 8-19-45 M. D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31667
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 W. Lombard St.
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Leacy.

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Mary Doyle Leacy
6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) June 27 1865

8. AGE: Years	Months	Days	If less than one day
80.	1	2	20 hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired brakeman
11. Industry or business Railroad

FATHER
12. Name Lawrence Leacy
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Dixon
15. Birthplace Ireland.

16 (a) Informant Mr. William J. Leacy
(b) Address 912 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Frederick Road Cath.
18 (a) Funeral director John J. Corcoran & Son
(b) Address 901-03 Hollins St.
19 (a) Filed by registrar Hunter Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17, 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945, to Aug 16 1945, and that I last saw h. l. alive on Aug 16 1945.

Immediate cause of death	Duration
Coronary thrombosis	3 days
Due to Generalized arteriosclerosis	20 yrs
C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Cooleahan M. D.
Address 2 W. Fayette St. Date signed 8/18/45

9 1945
Va 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G31668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31668

157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State South Carolina County
(c) City or town Columbia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 River Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Billie Gibson Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-23-38

8. AGE: Years	Months	Days	If less than one day
6	9	26	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marion Taylor
13. Birthplace South Carolina

MOTHER
14. Maiden Name Margaret Gibson
15. Birthplace South Carolina

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof Aug 19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Columbia S.C.
Location

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) Date received AUG 20 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1945 at 7 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1945 to 8-18 1945 and that I last saw him alive on 8-18 1945

Immediate cause of death Respiratory arrest — Duration

Due to Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-24-45

Major findings of operation: Fusion 4&5 for Pulmonary Stenosis

of autopsy: Single ventricle

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Elder Jr. M. D.
Address Johns Hopkins Date signed Aug 21

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. 631669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 W. Colvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7001 Brook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Thomas Wilburn Redding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/72

8. AGE: Years	Months	Days	If less than one day
73	5	21	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Timothy Redding
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Vaughan
15. Birthplace Ireland

16 (a) Informant Mrs. Honora K. Lewis
(b) Address Rockenbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22/45 (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Hickory Md

18 (a) Funeral director Degen & Todd
(b) Address Belair Md

19 (a) Date received by local registrar AUG 20 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1945 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1945 to Aug. 19 1945, and that I last saw him alive on Aug. 19 1945.

Immediate cause of death	Duration
Cerebral vascular accident	
Due to Hypertensive cardio vascular disease	
Due to Generalized arteriosclerosis Coronary Rheumatic Heart	
Other Conditions Cerebral Embolism, cardiac failure	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford M. Leatherbury Jr. M.D.
Address Union Memorial Hospital Date signed 8/19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G31670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 N. Greene Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Greene Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE C. REYNOLDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1913

8. AGE: Years	Months	Days	If less than one day
32	5	5	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Coat Checker

11. Industry or business

FATHER
12. Name Marcellus Reynolds
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Gordon
15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Reynolds
(b) Address 303 N. Greene Street

17 (a) Burial (b) Date thereof 8/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street.

AUG 20 1945 (b) Huntington Nottingham, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1945 to Aug 17 1945, and that I last saw h[illegible] alive on Aug 12 1945.

Immediate cause of death Bilateral Pulmonary Atelectasis

Due to Extreme Emaciation.

Due to Inanition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. G. Reedle, M.D.
Address 7324 - W. North Ave. Date signed 8/18/45

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631671

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. 631671

CERTIFICATE OF DEATH 122B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Hall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Heiliger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12th 1894

8. AGE: Years	Months	Days	If less than one day
51	1	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Pattern Maker
11. Industry or business Unknown

FATHER 12. Name	John J. Heiliger
13. Birthplace	Md.
MOTHER 14. Maiden Name	Lula Jones
15. Birthplace	Md.

16 (a) Informant Clara E. Heiliger
(b) Address 1727 Hall Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Pratt St

AUG 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945 at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Aug 18 1945 and that I last saw him alive on Aug. 18 1945

Immediate cause of death	Duration
Post-operative atelectasis	days
Due to Acute Intestinal Obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8/14/45
Major findings of operation: Acute Intestinal Obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. A. Geary & Associates M.D.
Address St Agnes Hosp Date signed 8/18/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G31672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Community Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5723 Bellona Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs Ella Boyer . (Anna M. Boyer)

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed.

6 (b) Name of husband or wife J. Stener

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1879

8. AGE: Years 66 | Months 0 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Charles F Wernig

13. Birthplace Md.

MOTHER 14. Maiden Name Angela Wentz

15. Birthplace Germany

16 (a) Informant W. S. Stoller

(b) Address 823 Glen Allen Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilson Co Inc

(b) Address 1317 Park Ave

AUG 20 1945 (b) Registrar Huntington Williams, M.D.
(Date filed)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945 at 7:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1945 to Aug 18 1945 and that I last saw her alive on Aug 18 1945

Duration

Immediate cause of death Cerebrovascular accident

Due to Hypertension and cerebrovascular disease

Due to Arteriosclerosis.

Other Conditions Carcinoma of Sigmoid, Caecatomy
(Include pregnancy within 3 months of death)

Date of operation Aug 7, 1945

Major findings of operation: Carcinoma of Recto sigmoid,

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Charles S Butler M. D.

Address Cent. Hosp. Date signed 8-18-45

VS 150

X

Filling write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G31673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 95
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Hundertmark

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Annie O.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24. 1879

8. AGE: Years 65 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Frederick Hundertmark

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Ankhorn

15. Birthplace Germany

16 (a) Informant Albert C. Hundertmark

(b) Address 3102 Orlando Ave.

17. Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)

(c) Cemetery or crematory Wadlowe

Location Wadlowe Md

18 (a) Funeral director Pilgrim Corp Inc

(b) Address 1217 E. Cold St

19 (a) AUG 20 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1945, at 4.00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mahaffey M.D. Medical Examiner.

Date signed 8/14/45

VS 151

G31674

HEP #68953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G31674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1-5
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Bangs

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1888

8. AGE: Years	Months	Days	If less than one day
57	0	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Bangs
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Bart
15. Birthplace Penna.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Wilson Line

18 (a) Funeral director Wilson & Son
(b) Address 2104 Pont St

19 (a) AUG 20 1945 (Date rec'd by registrar) (b) Thurlington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12, 1944 to Aug. 17, 1945, and that I last saw him alive on Aug. 17, 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Advanced bronchiectasis	
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B C H Date signed 8/18/45

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G31675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution: University Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10th day
(e) Length of stay in Baltimore (yrs., mos., or days) 4½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Vera Doris Wilson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, (married), widowed, or divorced: Married
6 (b) Name of husband or wife: John Wilson
6 (c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): July 12-1904
8. AGE: Years 41 Months 1 Days 6 If less than one day ____ hr. ____ min.
9. Birthplace: New York, N.Y. (Town, county, and state)
10. Usual Occupation: Actress
11. Industry or business: Stage shows

FATHER
12. Name: Unknown
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: John Wilson
(b) Address: 1402 Linden Ave
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18 (a) Funeral director: Hilborn & Hilborn
(b) Address: 1210 Eutaw Pl. (b) Huntington-Williamsport, Md.
Registered by (Registrar) AUG 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1945, at 2:04 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13th 1945, to Aug 18th 1945, and that I last saw h[er] alive on Aug 18th 1945.

Immediate cause of death: Toxemia — Duration: 7
Due to: Cirrhosis of the liver — Duration: Over 1 year
Due to:
Other Conditions: Malignancy had not been definitely ruled out.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: J. M. Parham M. D.
Address: University Hospital Date signed: Aug 18th 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

CHARLES F. LAUTERBACH

G31676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G31676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4108 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Lauterbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Lydia M. Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1887

8. AGE: Years	Months	Days	If less than one day
57	9	14	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Ice Dealer

11. Industry or business

FATHER
12. Name John C. Lauterbach
13. Birthplace Balto.

MOTHER
14. Maiden Name Emma F. Swift
15. Birthplace Va.

16 (a) Informant Mrs. Lydia M. Lauterbach
(b) Address 4108 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.20.45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave

19 (c) AUG 20 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27 1945, to Aug. 16, 1945 and that I last saw him alive on Aug. 16, 1945

Immediate cause of death Cerebral hemorrhage — Duration 2 days.

Due to Arterial hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd A. Kemp M. D.
Address 3030 Edmondson Ave. Date signed 8/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G31677 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 1132 Stockton St.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Stockton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearline Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1941

8. AGE: Years 3 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James Carroll
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Hattie Curtis
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Hattie Carroll
(b) Address 1132 Stockton St. (mother)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port

18 (a) Funeral director Wm Brooks
(b) Address 1463 McCaeg St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 20 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16-1945, at 4:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-1945, to 8-16-1945, and that I last saw her alive on 8-15-1945

	Duration
Immediate cause of death: Bronchopneumonia	4 days
Due to:	
Due to:	
Other Conditions: Infantile paralysis - 3 yrs. (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Saunders M. D.
Address 1029 N. Stricker Date signed

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G31678

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6201 Liberty Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Judy Anne Webb Judith Ann Webb

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-8-40

8. AGE: Years 5 | Months 7 | Days 10 | If less than one day: hr. min.

9. Birthplace Pa Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name George H. Webb
13. Birthplace Pa.

MOTHER
14. Maiden Name Lahja A. Terho
15. Birthplace Finland Springfield

16 (a) Informant Mr. George H. Webb
(b) Address JOHNS HOPKINS HOSPITAL 6201 Liberty Hgts Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director Wills Lamonaco
(b) Address 4510 Liberty Heights Ave.

19 (a) AUG 20 1945 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1945 at 9 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to Aug 18 1945 and that I last saw her alive on Aug 18 1945

Immediate cause of death: Acute myeloid leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Diffuse infiltration of organs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold G. Guild M. D.
Address Johns Hopkins Hosp. Date signed 8/18/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31679 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood or Lexington St.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Appleby Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Mamie Gourley~~ Emma Marie Gourley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24th, 1928

8. AGE: Years 16 | Months 7 | Days 24 | If less than one day: #### hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John C. Gourley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hazel M. Jones
15. Birthplace Baltimore, Md.

16 (a) Informant John C. Gourley (Father)
(b) Address 1320 Appleby Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) Registrar

AUG 20 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1945, at 2:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1945, to 8/17 1945, and that I last saw her alive on 8/17 1945.

Immediate cause of death Respiratory and Cardiac Failure — Duration: Month

Due to Chronic Glomerulo-Nephritis & Uremia, Hypertension & Anemia — Duration: Month

Due to Cardiac Enlargement & Valvular disease. — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. Mchugh Jr M. D.
Address Asst. Hosp. Date signed 8-17-45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any form of information should be carefully supplied. The

G31680

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 937

G31680 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town RURAL (If outside city or town limits, write RURAL and give town)
(d) Street No. Jacobsville, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-15-1905

8. AGE: Years	Months	Days	If less than one day
40.	6	4	hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Richard White
13. Birthplace Md

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md

16 (a) Informant Ernest Green
(b) Address Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mapothy Cem
Location A. A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) (Date received by Local Registrar) AUG 20 1945 (b) Huntington for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/45 at 4.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McCally M.D. Medical Examiner
Date signed 8/19/45

G31681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

G31681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5006 E. Oliver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 E. Oliver St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Fahey

3 (b) If veteran, name war — —

3 (c) Social Security Account No. 2a 3-03-0783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Bridget Fahey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-1877

8. AGE: Years	Months	Days	If less than one day
68	8	3	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Beth. Fairfield

FATHER
12. Name Fahey
13. Birthplace Ireland

MOTHER
14. Maiden Name —
15. Birthplace England

16 (a) Informant Mrs Bridget Fahey
(b) Address 5006 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park
Location Balto. Md.

18 (a) Funeral director Philip J. Henry & Sons
(b) Address 2024 Orleans St

19 (a) (Date received by registrar) AUG 21 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18- 19 45 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereof and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Squamous Carcinoma of Lip and Metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-18-45

AUG 1951

X

G31682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 W Hamilton St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W Hamilton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Evans Mitchell Stewart
3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Robt. O. Stewart
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept. 11 1870
8. AGE: Years 74 Months 11 Days 8 If less than one day hr. min.
9. Birthplace Phila Pa. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Alexander Mitchell
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Henrietta Stump
15. Birthplace Perryville Md.

16 (a) Informant Mr. Stewart (son)
(b) Address 10 W Hamilton St
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Nottingham Location Cecil Co. Md.
18 (a) Funeral director Stewart Mortuary
(b) Address 1918 W North Ave.
19 (a) AUG 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 45, to Aug 19 1945, and that I last saw h[illegible] alive on Aug 19 1945.

Immediate cause of death Cardiac failure — Duration 20 min.

Due to Hypertension and C. V. D.

Due to Cerebral Hemorrhage

Other Conditions Chronic, duodenal ulcer

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Mitchell M.D.
Address 10 W Hamilton Date signed 8/20/45

X.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G31683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31683 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 Parkside Drive
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Katherine Ruths

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 7-1861

8. AGE: Years	Months	Days	If less than one day
83	10	10	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER
12. Name George Ruths.
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Nily
15. Birthplace Germany

16 (a) Informant Mr. Robt Ruths
(b) Address 3204 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20-45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Balto. Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1412 Hollins St

19 (a) (Date received by Registrar) AUG 20 1945 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1945, at 1.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945, to Aug 17 1945, and that I last saw h[illegible] alive on Aug 17 1945.

Immediate cause of death Cardiac failure & pulmonary congestion

Due to Hypostatic cardiac vascular disease

Due to —

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration
4 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Hutchinson J. Mitchell M. D.
H. W. Muldrow Date signed

93 D 8/17/45

G31684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31684

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 YRS
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 OAKLEY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS TABACK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. ~~Widowed~~ Married

6 (b) Name of husband or wife ~~[redacted]~~ Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace POLAND

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace POLAND

16 (a) Informant HOSPT RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location O'DONNEL ST.

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) AUG 20 1945 (Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...,
and that I last saw h... alive on ..... 19...

Immediate cause of death Coronary occlusion — Duration

Due to Hypertensive arteriosclerotic C.V. disease

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Hamburger M.D.
Address Sinai Hospital Date signed 8/18/45

Huntington Williams, M.D. Edmund J. Marcus, M.D.

VS 180

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31685 ✓ 478990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31685 ✓ Registered No.

Please answer questions on this side of certificate. Answer all questions. Use ink. Type or print plainly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abr. Bernstein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	W

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace England. (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ? ?
13. Birthplace England

MOTHER
14. Maiden Name ? ?
15. Birthplace England.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jos. Levy Sons
(b) Address 1439 E. Balto St

19 (a) AUG 20 1945 (Date rec'd by Registrar) (b) Registered No.

Hearing for Williams M.E.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1945, at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1945, to Aug. 20 1945, and that I last saw h[illegible] alive on Aug. 20 1945.
Immediate cause of death: Respiratory failure due to subarachnoid space hemorrhage into
Due to Generalized arteriosclerosis
SUBARACHNOID -
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Dieter
Address Johns Hopkins Hospital 8/20/45

VS 150

X

G31686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G31686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. High St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME MICHAEL CHRISTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1884

8. AGE: Years	Months	Days	If less than one day
61	5	23	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Door Man

11. Industry or business

FATHER
12. Name Rocco Christy
13. Birthplace Italy

MOTHER
14. Maiden Name Laura Lann
15. Birthplace Italy.

16 (a) Informant Mrs. Lena Monfredo
(b) Address 1752 Homestead St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgian Rd, Balto Md

18 (a) Funeral director Frank Dallas Mack
(b) Address 52 N. Wesley Ave

19 (a) Date received AUG 20 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945, at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945 to Aug 19 1945, and that I last saw him alive on Aug 9 1945.

Immediate cause of death	Duration
Lymphosarcoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/2/45

Major findings of operation: Lymphosarcoma (biopsy)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry W. Camp M. D.
Address Mercy Hosp. Date signed 8/19/45

OVER

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31687 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Julia Buczkowska

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Franks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wypsiecki
13. Birthplace Poland.

MOTHER 14. Maiden Name
15. Birthplace Poland

16 (a) Informant Carl Buczkowski
(b) Address 2012 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Delivered to undertaker) (b) Hunting for Will Applied for

AUG 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1943 to Aug 18 1945 and that I last saw her alive on Aug 18 1945.

Immediate cause of death	Duration
TERMINAL BRONCHO-PNEUMONIA	8/15/45
Due to CEREBRAL THROMBOSIS	8/2/45
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE	1943
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geoff F. Drenga M. D.
Address 209 E. Chester St Date signed 8/20/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31688 — w 2/m — Dallmyer — 2311 Garrison Blvd — G31688

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 186a

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2311 Roslyn Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 Roslyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Nelson

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Ella Eddy
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 9 1857
8. AGE: Years 94 | Months 1 | Days 9 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Richard Nelson
13. Birthplace: Md

MOTHER
14. Maiden Name: Delilah Miers
15. Birthplace: Md

16 (a) Informant: Mrs J. B. Parker
(b) Address: 2311 Roslyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/21/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md

18 (a) Funeral director: Fulhorn & Son
(b) Address: 1317 Park Ave

19 (a) (b) Registrar: Huntington Williams

AUG 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1945 to Aug 18 1945 and that I last saw him alive on Aug 18 1945.

Immediate cause of death: Hypostatic pneumonia — Duration: March 14-45
Due to: Fracture of the left hip — March 14-45
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: accident
(b) Date of occurrence: March 14-1945 at 2 P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? no
(e) Means of injury: Fell down in room

23. Signature: William J. Sullivan M. D.
Address: 2911 Garrison Blvd Date signed: Aug 20 45

Howard J. Thomsen, M.D. X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31689
CWK-95518

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31689
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) 15 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Dundalk Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Arthur Heath, Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3-1944

8. AGE: Years	Months	Days	If less than one day
1	3	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Arthur Heath
13. Birthplace Maryland

MOTHER
14. Maiden Name Hilda Williams
15. Birthplace West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director George R. Weber
(b) Address 705 S. Linn street

19 (a) AUG 20 1945 (Date received by Registrar) (b) Huntington, W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1945, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1945, to Aug. 18 1945, and that I last saw him alive on Aug. 18 1945.

Immediate cause of death	Duration
Aspiration of Vomitus and Respiratory Obstruction	1 hour
Due to	
Due to	
Other Conditions 2° Burns of Left Abdomen, Pubis & Legs	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ acc.
(b) Date of occurrence 8-18-45 at 7:45 P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury Hot Water Burn
23. Signature William A. Galat M.D.
Address Baltimore City Hosp. Date signed 8-19-45

VS-150 Subject to the approval of the Medical Examiner
For S. J. C. Sheehan - Howard J. Malone, M. D.

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G31690

HEP # 95061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G31690

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 19 19 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Upton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnson, Charles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1894

8. AGE: Years	Months	Days	If less than one day
50	7	28	hr. min.

9. Birthplace West Africa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Johnson (D)
13. Birthplace Africa

MOTHER
14. Maiden Name Isabelle ? (D)
15. Birthplace Africa

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Presstman St

AUG 20 1945 (Date rec'd by registrar)

(b) Huntington Withdrawn, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1945 to Aug. 17, 1945 and that I last saw him alive on Aug. 17, 1945.

	Duration
Immediate cause of death: Cerebral Embolism	7
Due to: Syphilitic Aortic Insufficiency	7
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan, M. D.
Address Baltimore City Hosp. Date signed 8-18-45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 46 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Durham (If outside city or town limits write RURAL and give town)
(d) Street No. 1702 Fayetteville St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME William Hill

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7. 9. 1890

8. AGE: Years 55 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Va (Town, county and state)

10. Usual Occupation accountant

11. Industry or business insurance

FATHER
12. Name Reuben Hill
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant E. N. Randall
(b) Address 1301 Penna. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)
(c) Cemetery or crematory Durham
Location Durham, N. C.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1003 Pearstman St.

19 (a) AUG 20 1945 (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 8. 19 1945, at 11¾ M

21. I certify that death occurred on the date above stated; that I attended deceased from 7. 5. 1945 to 8. 19. 1945 and that I last saw h[illegible] alive on 8. 19. 1945

Immediate cause of death	Duration
Bronchopneumonia	36 hrs
Due to congestive heart failure	5 days
Due to hypertensive cardiovascular renal disease	18 mos
Other Conditions diabetes mellitus	21 yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James D. Cars, M. D.
Address 515 Morbert St Date signed 8-30-45

131a

631692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631692

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Baker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Jannie Bishop Gerald Lorraine Ruth Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1 1920

8. AGE: Years 24 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Esther Johnson
15. Birthplace Md.

16 (a) Informant Barnabas Bishop
(b) Address 1508 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md

18 (a) Funeral director Thomas E. Jefferson
(b) Address 1303 Pennsylvania Ave

19 (a) AUG 20 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1945 at 3 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/18/45 at 2:30 P M.
(b) Where did injury occur? 1500 blk. of Baker St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Pedestrian struggle by Hit and Run Driver

23. Signature Howard J. Andersen M.D. Medical Examiner

Date signed 8-18-45

VS 151

G31693 95458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31693

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6209 Birchwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ellen Inwold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Warren Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1923

8. AGE: Years	Months	Days	If less than one day
22	1	7	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Brady
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Basel
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Cem.
Location Baltimore

18 (a) Funeral director L. J. Rush
(b) Address 5305 Radford Rd.

19 AUG 20 1945 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1945 to Aug. 18 1945 and that I last saw h. alive on Aug. 18 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: f
of autopsy: findings not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address BCH Date signed 8/15/45

VS 150

631694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

631694 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4518 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4518 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Gagnon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Roberline V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11. 1862

8. AGE: Years	Months	Days	If less than one day
82	9	5	hr. min.

9. Birthplace Kankee Co. Illinois (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Balto. Granite Co.

FATHER
12. Name Francis Gagnon
13. Birthplace Canada

MOTHER
14. Maiden Name Victorine Casse
15. Birthplace Canada

16 (a) Informant Mrs. Roberline Gagnon
(b) Address 4518 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Kusk
(b) Address 5305 Harford Road

19 (a) Date received by registrar 8-20-1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 45 to Aug 16 19 45 and that I last saw h.m. alive on Aug 16 19 45

Immediate cause of death Carcinoma of Bladder — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Tourney M.D.
Address 4 E. S. Edwood Rd. Date signed 8/18/45

X

G31695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G31695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1:½Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 23.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Addison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dressel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19 - 1945

8. AGE: Years | Months | Days | If less than one day 1 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Earl Frederick Dressel Sr.
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary Theresa Zentgraf
15. Birthplace Baltimore Md.

16 (a) Informant Earl Frederick Dressel
(b) Address 106 S. Addison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George L. Schwartz
(b) Address 2101 Frederick Rd. Catonsville, Md.

19 (a) AUG 20 1945 (Registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19-45 19 11:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10:15 P.M. 8/19 19 45 to 11:30 P.M. 8/19 19 45 and that I last saw h alive on 19

Immediate cause of death	Duration
Congenital atelectasis	
Due to Incomplete development of body organs	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Schwartz Jr. M. D.
Address Bon Secours Hosp. Date signed 8/20/45

G31696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31696

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 50 E. Montgomery St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 50 E. Montgomery St (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ellen Virginia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER

12. Name Nathaniel Lightner

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Catherine

15. Birthplace Pennsylvania

16 (a) Informant Rev. B. F. Lightner

(b) Address 200 E. Middle St., Gettysburg Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 21, 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Gettysburg, Pa.

18 (a) Funeral director John F. Denny, Inc

(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b)

VS 150 AUG 20 1945

Huntingtown, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 18 1945 and that I last saw h[illegible] alive on Aug 17 1945

Immediate cause of death Diabetic Coma — Duration 3 days

Due to Diabetes — Duration ?

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature [illegible] M.D.

Address [illegible] Date signed 8/20/45

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

631697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 C

631697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd, at Calvert Sts.,
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL, and give town)
(d) Street No. 5611 Magnolia Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Reiter.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Katherine M. Reiter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	11	0	hr. min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual Occupation Cabnet Maker ?
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Hungary ?

MOTHER
14. Maiden Name unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Frederick F. Reiter,
(b) Address 5611 Magnolia Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location A. A. County Md.

18 (a) Funeral director C. Vernon Lamon
(b) Address 4611 Park Heights Ave.,

19 (a) AUG 20 1945 (Date rec'd by registrar) Huntingtor Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1945, at 4 35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to him death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral lacerations + hemorrhage
Due to Bullet, self inflicted
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-45 at 11 A. M.
(b) Where did injury occur? 5611 Magnolia Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? no
(d) Means of injury Shot self with rifle.

23. Signature Joseph H. Sheehan M.D. Medical Examiner.
Date signed 8/18/45

Sheehan

G31698 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1321a

G31698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 E Preston
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 E Preston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John Joseph Kelly | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years about 58 | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Home Keeper

11. Industry or business

FATHER 12. Name John Keaveney

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McKeever

15. Birthplace Ireland

16 (a) Informant Miss Gertrude Kelly

(b) Address 1007 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 3rd Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons

(b) Address 3118 Eight St.

19 (a) AUG 20 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1945 to 8/19 1945, and that I last saw her alive on 8/19 1945

Immediate cause of death Arteriosclerotic Cardiovascular Renal Disease | Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M. D.
Address 1206 E. Preston St. Date signed 8/20/45

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31699 Registered No. 119a (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 N. Calvert St
(c) Hospital or institution: D.O.A. Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Calvert St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 19584

3 (a) FULL NAME Richard Dziekan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age 2/16/45 years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1945 Hartman Hospital

8. AGE: Years | Months 6 | Days 3 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Not Married

13. Birthplace

MOTHER 14. Maiden Name Magdaleph Dziekan

15. Birthplace Pa

16 (a) Informant Elizabeth Dziekan

(b) Address 619 N Calvert

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel Co.

18 (a) Funeral director J. Bailey Hanna

(b) Address 1300 Eutaw St

19 (a) AUG 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1945 at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from D.O.A. 19 and that I last saw h alive on 19

Immediate cause of death Diarrhoea — Duration Hours

Due to Unknown

Due to

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A.A. Steiner Jr. M.D.

Address Mercy Hosp Date signed 8/19/45

VS 150

Dr. J.B. Davis, - Howard J. Abrams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31700 Tate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G31700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Kingston Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Kingston Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert H Tate

3 (b) If veteran, name war ***

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Pearl S. Tate

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) April 16, 1860

8. AGE: Years 85 | Months 4 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Postman U.S. Mail

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Pearl S. Tate
(b) Address 506 Kingston Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) AUG 20 1945 (Date rec'd by registrar) Huntington White ... M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to Aug 19 1945, and that I last saw h alive on Aug 19 1945.

	Duration
Immediate cause of death: Myocarditis	4 mos
Due to: Senile debility	
Due to: from Cerebral Thrombosis	
Other Conditions: Enlarged Prostate for 2 yr	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Mrs Robt Tate

23. Signature John H Evans M. D.
Address 6 W 40 St Date signed

VS 150

X

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. ... information should be carefully supplied. The

G31701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G31701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 251 S. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 251 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George W. Wood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1863

8. AGE: Years 82 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Miller
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Jennie Snoops
(b) Address 2529 Jefferson St.

17 (a) Burial (b) Date thereof Aug. 21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director John L. Miller
(b) Address 2534 Jefferson St.

(a) (b)
Date received by registrar AUG 20 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Aug. 17 1945
and that I last saw her alive on Aug 17, 1945.

Immediate cause of death Acute Bronchio-Pneumonia — Duration 1 wk.
Due to Primary
Due to
Other Conditions Cerebral Sclerosis & Chr. Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jennie Snoops M. D.
Address 1007 E. Rattle Date signed 8/20/45

631702 WILLIAM H. HENRY 631702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway near Fayerweather Ave
(c) Hospital or institution Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Chestnut Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. H. Henry

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mabel F. Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2-1874

8. AGE: Years	Months	Days	If less than one day
71	—	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Ry. Railroad
11. Industry or business Retired 6 years

FATHER
12. Name Aaron Henry
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Boone
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Clark M. Brown
(b) Address 3104 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Durae Funeral Home
(b) Address 3621 Falls Road

19 AUG 20 1945 (b)
(Date rec'd by Registrar) Hamilton for Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/1945 at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Joseph L. Shenken M.D. Medical Examiner.
Date signed 8/19

VS 151

X

G31703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31703 Registered No. 164E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Cabrel Streets
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Remington Avenue (If rural R.F.D. location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lizzie L. Jones

6 (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9-1878

8. AGE: Years 67 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Ry. Railroad

11. Industry or business Retired 7 years

FATHER
12. Name Frederick Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Frances Hay
15. Birthplace Maryland

16 (a) Informant Mrs. Lizzie L. Jones
(b) Address 3110 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21-1945 (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

19 (a) AUG 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1945 at 8 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to multiple lac & contusions

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-45 at 6:55 P.M.
(b) Where did injury occur? Huntington Ave Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Jumped from bridge.

23. Signature Joseph L. Sheehan M.D. Medical Examiner.
Date signed

VS 151

G31704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31704 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2677 Fredericks Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2677 Fredericks Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph H. Miller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 17 1856

8. AGE: Years 89 | Months 3 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Ellicott City, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Lilly
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Keith
15. Birthplace Md.

16 (a) Informant Franklin H. Miller
(b) Address 2677 Fredericks Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. A. Wappler & Son
(b) Address 300 Eutaw Place

19. (a) Aug 20 1945 (Date received by registrar) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th 1945, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Aug 16 1945, that I last saw her alive on Aug 17 1945

Immediate cause of death
Cerebral Hemorrhage — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Colleran M.D.
M. D.
Address 3321 Frederick Date signed

VS 150

X aw 8-19-45

G31705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154B

Registered No. G31705

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Albert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8- 1908

8. AGE: Years	Months	Days	If less than one day
36	10	10	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Joseph Albert Sr
13. Birthplace Austria

MOTHER
14. Maiden Name Adele Satorius
15. Birthplace Austria

16 (a) Informant Joseph Albert Sr
(b) Address 2420 Wilkens

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 '45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director L. D. Nippert & Son
(b) Address 320 Eutaw Place

19 (a) Aug 20 1945 (b)
(Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1945 at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1945 to Aug. 18 1945, and that I last saw h[illegible] alive on Aug. 18 1945

Immediate cause of death	Duration
Uremia	
Due to Chronic Infection (Osteomyelitis)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose Calvary de Chanderna M.D.
Address St Agnes Hospt. Date signed 8/18/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Street
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 East 41st St. City, 18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph L. Bartlett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Mrs. R. L. Bartlett
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Dec. 19, 1884
8. AGE: Years 60 | Months 8 | Days 0 | If less than one day ____ hr. ____ min.
9. Birthplace Mass.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Edward Bartlett
13. Birthplace Mass.

MOTHER
14. Maiden Name Annie Hale
15. Birthplace Mass.

16 (a) Informant Wife
(b) Address 502 East 41st City, 18
17 (a) Removal (b) Date thereof 8-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Lebanon Pa.
18 (a) Funeral director William Cole Inc.
(b) Address 1217 St. Paul St.
20 Aug 1945 Filed Aug 21 1945 Wilmington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1945 at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death Uremia — Duration 7 days
Due to Pyelonephritis — 2 yrs.
Due to Benign Prostatic Hypertrophy
Other Conditions Hypertensive Cardiovascular Renal Disease, Arteriosclerosis
(Include pregnancy within three months of death)
Date of operation
Major findings of operation:
of autopsy: Pyelonephritis, HCVRD

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Crawford M. Kirkpatrick Jr.
Address Union Memorial Hospital Date signed 8/19/45

VS 190

Hospital X

Coroner's case is especially important. Physicians: please write the causes of death clearly and legibly.

missing —
G31707

G31708 BALTIMORE CITY HEALTH DEPARTMENT G31708

CERTIFICATE OF DEATH 477

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Presstman
(b) Street address 3006 Presstman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 57-4-29

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co
(c) City or town Balto 7
(If outside city or town limits write RURAL and give town)
(d) Street No. 3006 Presstman St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Attilio L. Schiaffino

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 215-09-5207

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rosalie L Schiaffino
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) March 19-1889

8. AGE: Years	Months	Days	If less than one day
57	4	29	..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Giovanni Schiaffino
13. Birthplace Italy

MOTHER
14. Maiden Name Paolina Marsala
15. Birthplace Italy

16 (a) Informant Rosalie L Schiaffino
(b) Address 3006 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn
18 (a) Funeral director B-L-Hopkins
(b) Address Annapolis, Md.
19 (a) ..... (b) ..... (Date of filing) (Registrar) Augustus Williams, Registrar

AUG 21 1945

VB 5

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1945, to Aug. 17, 1945, and that I last saw him alive on Aug. 16, 1945

Immediate cause of death	Duration
Carcinoma - liver & lung (Rt)	2 mos.
Due to ✓	
Due to ✓	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cannon M. D.
Address 514 Drury Lane Date signed 8/18/45

X

G31709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓119a

Registered No. G31709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 28 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Highwood DRIVE, City
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME KENNETH LEROY MILLS, JR.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 23, 1945.

8. AGE: Years	Months	Days	If less than one day
0	0	28	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation 0
11. Industry or business

FATHER
12. Name Kenneth L. Mills Sr.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Oberle
15. Birthplace Balto. Md.

16 (a) Informant Parents
(b) Address 614 Highwood Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/45 (month) (day) (year)
(c) Cemetery or ~~Cemetery~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1945, at 12:38 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to Aug 20 1945 and that I last saw him alive on Aug 20 1945.

Immediate cause of death ACUTE NUTRITIONAL DIARRHEA — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M my Spencer
Address U M H. Date signed 8-20 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127B

Registered No. G31710

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave.
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Phoebe Jane Wolfe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
53 ??			hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Registered Nurse
11. Industry or business

FATHER
12. Name George H Wolfe
13. Birthplace Funkstown, Md.

MOTHER
14. Maiden Name Emilie Jane Heil
15. Birthplace Hagerstown, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 month (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director Mc Sweeney & Sons
(b) Address Hagerstown Md

19 (a) Filed Aug 21 1945 Registrar for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/1941, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1941 to 8/20 1941, and that I last saw h alive on 8/20 1941

Immediate cause of death: Multiple Sclerosis
Due to respiratory failure
Due to
Other Conditions Gall Bladder Case.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Leavitt, A. M.D.
Address W. Ogden Hosp Date signed 8/20/41

G31711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. G31711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 536 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL)
(d) Street No. 536 Baker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Edwards.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Edwards

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Thomas Jefferson Edwards

13. Birthplace N. C.

MOTHER 14. Maiden Name Elizabeth ?

15. Birthplace N. C.

16 (a) Informant Mary Edwards

(b) Address 536 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A. Halsteadt

(b) Address 918 Druid Hill Ave

19 (a) AUG 21 1945 (Date rec'd by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/45 19 . at 6½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/1945 to 8/17/1945, and that I last saw h[illegible] alive on 8/16/1945.

Immediate cause of death	Heart-failure	Duration
Due to	Hypostatic Congestion	
Due to	Pneumonia	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayland F. Jones M. D.

Address 1300 N. Broadway Date signed 8/18/45

VS 150

X

G31712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G31712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Peters st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert McKelvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director A. Hollstead
(b) Address 918 Druid Hill Ave.
19 Date received AUG 21 1945 (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1945, at 2:05 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple stab wounds of chest involving lungs.

Due to Stab wounds of neck

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1 A.M. at 8-13-45 M.
(b) Where did injury occur? 142 East Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Stabbed

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-13-45

G31713 Grave # 15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 Registered No. G31713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Boogs

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 21 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25/45 19 at 3.75 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said ~~Autopsy~~, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma, Rt. breast

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? (While at work?
(d) Means of injury

23. Signature John L. Davis M.D.
Medical Examiner.
Date signed 7/25/45

G31714

A 42576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G31714

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 311 Elm Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Reid

G 27473

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1945

8. AGE: Years	Months	Days	If less than one day
	1	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Kathrine Reid
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 21 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 5 - 1945 at 2 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3- 1945 to 8-5- 1945 and that I last saw her alive on 8-5- 1945

Immediate cause of death
Respiratory failure

Due to Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond M. D.

Address Date signed

VS 150

L2903

X

G31715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G31715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Cathedral St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hours
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Turney

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/45

8. AGE: Years | Months | Days | If less than one day: 9 hr. 16 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Edward Turney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Jane Turney
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 1624 Eutaw Place

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 21 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1945 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1945, to 8-17 1945, and that I last saw her alive on 8-17 1945.

Immediate cause of death: Respiratory Failure. — Duration: 1 day

Due to: Premature (30 Weeks - 2 lbs.)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bobbie T. Caine M.D.
Address Franklin Square Hosp. Date signed 8-18-45

Physicians: please write the causes of death clearly and legibly. Be sure that the information entered is correct and complete. Any necessary supplies. The correct age is especially important.

VS 180 2905

G31716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31716

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Prestman St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife George Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
36 yrs.			hr. min.

9. Birthplace Bell Haven, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ed. Stichel
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Cayers
15. Birthplace Va.

16 (a) Informant Geo. Hall
(b) Address 1500 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. J. Nelson
(b) Address 1303 Prestman St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

AUG 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-45 19 , at 9 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10-45 19 , to 8-18-45 19 , and that I last saw her alive on 8-18-45 19 .

Immediate cause of death Cardiac Failure — Duration 4 days
Due to Chronic Bright's Disease — Duration 5 yrs
Due to — Duration
Other Conditions Hypertension & Chronic Passive Congestion — Duration undetermined
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Cooley M.D.
Address President Hospital Signed 8/20/45

Cooley

G31717 ✓ G31717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N. Gilmor St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Gilmor St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Clarence Briscoe.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-2661

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	colored	Widowed

6 (b) Name of husband or wife Eva Brisoe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1887

8. AGE: Years	Months	Days	If less than one day
58	7	15	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Elizabeth Harris
(b) Address 504 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

AUG 21 1945

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Aug 16 1945 and that I last saw h— alive on 8-16 45

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to: Hypertension

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature E. L. Pipes M.D.
Address 836 W. Lanvale St Date signed 8-17-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 C ✓

G31718 Registered No.

correct age is especially important, Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Holbrook St.
(c) Hospital or institution:

95 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Holbrook St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles M. Kinnaird

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Myrtle Reed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th 1872

8. AGE: Years	Months	Days	If less than one day
73	3	11	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Printing

FATHER
12. Name (Unknown) Kinnard
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Harry H. Kinnaird
23 Fairview Ave, Clarksburg W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)
(c) Cemetery or crematory Balto Md
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) AUG 21 1945 (Date rec'd by registrar) (b) Registrar

Huntington W Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19th 1945, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1944 to Aug 19 1945, and that I last saw h alive on Aug 18 1945

Immediate cause of death: Cardiac insufficiency — Duration: 4 hrs
Due to: Senile degeneration — 5 yrs
Due to: Hypertension — 2nd Duration
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randolph Grove M. D.
Address 2438 Maryland Ave Date signed Aug 20 45

425 X

G31719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G31719 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) ~~Hospital~~ or institution: Balto. City Hospital DOA
(d) Length of stay in hospital or ~~last~~ illness (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul J. Lazur

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 19, 1934

8. AGE: Years	Months	Days	If less than one day
11	1	0	hr. min.

9. Birthplace Latrobe, Pa. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Paul Lazur
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Lucas
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Catherine Buckner
(b) Address 3120 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Filed by registrar) AUG 21 1945 Registrar
Hunting for Attorney

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1945, at 2 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2 P. at August 19, 1945
(b) Where did injury occur? Holly Beach, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 8-20-45

X

G31720 247059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9/a

Registered No. G31720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Thorpe Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Jordan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-22

8. AGE: Years	Months	Days	If less than one day
23	-	29	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Willie Jordan
13. Birthplace Va

MOTHER — 14. Maiden Name Mary Street
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg Va.

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1229 N. Caroline St.

19 AUG 21 1945 (Date rec'd by local registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 40

20. DATE OF DEATH Aug. 19, 1945 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1945 to Aug 19 1945 and that I last saw her alive on Aug 19 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Subacute Bacterial Endocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 8/19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X.

G31721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G31721

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Glendower Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Glendower Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter H. Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Nov 8, 1885

8. AGE: Years 59 | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business American Ice Co.

FATHER 12. Name William J. Stallings

13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary E. Cavanaugh

15. Birthplace Balto Md

16 (a) Informant Mrs Andrew L. Manning

(b) Address 1001 Maiden Choice Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 22 45 (month) (day) (year)

(c) Cemetery or crematory London Park Cem

Location 3800 Edgecliff Ave

18 (a) Funeral director John F. Conway Son

(b) Address 901 Hollins Street

19 (a) (Certificate received) (b) Registrar

AUG 21 1945

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18th 1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1945 to 8/18 1945, and that I last saw h[illegible] alive on 8/18 1945.

	Duration
Immediate cause of death: Acute Cardiac Failure	1 da
Due to: Hemoplegia, Right	
Due to: Hypertension Cardio-Vascular Renal Disease	3 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H. Lankenau M.D.

M. D.

Address 1211 Washington Blvd Date signed 8/20/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G31722

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
81 80			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Brown
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Turnbull
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by registrar) (b) Registrar

AUG 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 8 1945 to AUG 19 1945, and that I last saw h, Malive on AUG. 19 1945

Immediate cause of death Chronic Cardio conditis died suddenly — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Otto H. Decker M. D.
Address 928 E. North Ave Date signed 8/21/45

Assisting for Williams, M.D.

X

631723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

631723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Gurley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 4 N. Gurley Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Woodward

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence Woodward
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept. 17 1885

8. AGE: Years	Months	Days	If less than one day
59	11	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Unemployed

FATHER
12. Name George E. Woodward
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Katie Camel
15. Birthplace Baltimore Md.

16 (a) Informant Florence Woodward
(b) Address 4 N Gurley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director John C Meller Inc
(b) Address 2430 E. Oliver St

19 (a) AUG 21 1945 (Date received by local registrar) Registrar
Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1945, at 11:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Adeno-carcinoma of the caecum.
CAECUM

Due to

Other Conditions Acute diffuse peritonitis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellis M.D. Medical Examiner.
Date signed August 20, 1945

VS 151

G31724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G31724
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Fleming

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Blanka
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Ogreta Davidson
(b) Address 2011 Linden Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)
(c) Cemetery or crematory Maryland
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Oleans Street

19 (a) AUG 21 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 45 19 , at 1:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronic Myocardial Degeneration

Due to

Other Conditions Diabetes.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed August 21, 1945.

VS 151

G31725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31725

Registered No.

Please write plainly in ink or use typewriter. Do not use abbreviations. Be careful to spell out full name and address. Be careful and accurate in answering every question. Where there is no entry to be made, write "None" or "Unknown" so as to show that no question has been overlooked. Be careful to fill in correct age if it is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Carrollton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Leather -
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Annie E Leather
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov 15 - 1873

8. AGE: Years	Months	Days	If less than one day
71	9	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John L Leather
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary R Lanehart
15. Birthplace Maryland

16 (a) Informant Mrs J F Leather
(b) Address Carrollton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/45 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 21 1945

Huntington Whitehall Md

vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 20 1945, at 7 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 18 1945 to 8 - 20 1945, and that I last saw him alive on 8 - 20 1945.

Immediate cause of death	Duration
Cardiac failure -	
Due to Coronary thrombosis	
Due to Arteriosclerosis	
Other Conditions Ch. uremia - DM. Traumatic ulcers -	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George R. Callender M. D.
Address University Hosp. Date signed 8-20-45

X

G31726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G31726

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 N. Fulton Ave.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 N. Fulton Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Good

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or ~~wife~~ Abraham J. Good

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1874

8. AGE: Years 71 | Months 7 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John Hayes
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Daunt
15. Birthplace Ireland

16 (a) Informant Mr. Abraham J. Good
(b) Address 1909 N. Fulton Ave.,

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Aug. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

AUG 21 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1945 at 3-40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Aug 19 1945.
and that I last saw her alive Aug 19 1945
Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis

Duration 6 Yrs 7 Days

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, etc.)
(e) Means of injury

23. Signature H. Howard Strong M.D.

Address 4922 W. North Ave Date signed Aug 20 1945

D-31727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. D-31727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1374 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1374 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Luther Gaskins

3 (b) If veteran, name war none
3 (c) Social Security Account No. 212-09-3496

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Susie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1900

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Celia Gaskins
15. Birthplace Va.

16 (a) Informant Susie Gaskins
(b) Address 1374 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelly
(b) Address 1313 Presstman St

19 AUG 22 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 8/20 1945 and that I last saw h[illegible] alive on 8/20 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Burkhardt M. D.
Address 2134 W. N. Ave Date signed 8/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31728

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G31728 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Melville Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Melville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM N.T. STEIN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amelia Stein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1862

8. AGE: Years	Months	Days	If less than one day
83	6	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Cabinet maker
11. Industry or business

FATHER
12. Name Edward Stein
13. Birthplace Dont know

MOTHER
14. Maiden Name Dont know
15. Birthplace Dont know

16 (a) Informant Mrs. Amelia Stein
(b) Address 605 Melville Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) 1945 (Date filed by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17, 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 16 1945, and that I last saw h[illegible] alive on Aug 16 1945

Immediate cause of death Acute cardiac failure — Duration

Due to Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M.D.
Address 5217 Harford Rd Date signed 8-21-45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G31729

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Patapsco Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Patapsco Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amalia A. Hofmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9 - 1887

8. AGE: Years 58 | Months 7 | Days 8 9 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Hofmann
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Boppre
15. Birthplace Germany

16 (a) Informant Mrs. Barbara Scully
(b) Address 1414 Patapsco Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway 99.6

18 (a) Funeral director Elizabeth Hart Sms
(b) Address 115 E. West St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 21 1945 Thanksgiving Millers, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945 at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 18 1945 and that I last saw h alive on Aug 18 1945

Immediate cause of death: Cerebral Hemorrhage

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard St Date signed Aug 20 45

47 8491 631730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

631730

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 Sollers Point Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Tyler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	married

6 (b) Name of husband or wife Lehman
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1911

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace N. Ga.
(Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER — 12. Name	Emanuel ? Caldwell
FATHER — 13. Birthplace	? ? N. C
MOTHER — 14. Maiden Name	Hollie ? Barnard
MOTHER — 15. Birthplace	? ? N. C

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elizabeth Ave. Md
Funeral Home Chas. H. Chase Sons

18 (a) Funeral director
(b) Address 638 N Gilmor St

(a) (b)
(Date received by registrar) Registrar

AUG 31 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION E

20. DATE OF DEATH August 18 1945 at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Aug 18 1945 and that I last saw h[illegible] alive on Aug 18 1945

Immediate cause	Duration
Respiratory failure	
Due to Hypertensive cardiovascular renal disease	
Due to Cardiac failure	
Other Conditions Edema Obesity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 8/18/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 6

G31731

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 379 Evesham Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME HAWK HORST L. Alfred HAWICK HORST ✓

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-01-6825

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(Separated) M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11 1900

8. AGE: Years	Months	Days	If less than one day
44	10	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Joseph Hawkhorst
13. Birthplace Baltimore

MOTHER
14. Maiden Name Regina Schmitt
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balas Rd, Baltimore

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Pennsylvania Ave. Towson

19 (a) (This space for registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1945, at 11 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 11 1945, to Aug 19 1945, and that I last saw him alive on 8-19 1945.

Immediate cause of death	Duration
aspiration	
Due to meningitis	10 days
Due to probable meningo-coccus	
Other Conditions diabetic coma	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 8-20

VS 8

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31732 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 So Light St.

(c) Hospital or institution: So. Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 223 Pontiac Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Cahill

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Anna Cahill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1889

8. AGE: Years	Months	Days	If less than one day
56 57	2	1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Fireman (Retired)

11. Industry or business

FATHER 12. Name William Cahill

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Ambrose

15. Birthplace Ireland

16 (a) Informant Anna Cahill

(b) Address 223 Pontiac Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location Baltimore County

18 (a) Funeral director John M. Welch

(b) Address U.D. 5 Chester Street

19 (a) (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1945, at 9.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to Aug 19 1945 and that I last saw h[illegible] alive on Aug 19 A 45

Immediate cause of death	Duration
Myocardial Infarction.	
Due to Coronary Occulsion Thrombosis or	
Due to Arteriosclerotic Coma.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. Ehrlich

Address 1213 Light St. Date signed 8-19-45 M. D.

X

631733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. 631733 (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Freeman 408489

3 (b) If veteran, name war —	3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1944

8. AGE: Years	Months	Days	If less than one day
	11	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Larry Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Mary Freeman
15. Birthplace Md

16 (a) Informant Mary Freeman mother
(b) Address 1419 N. Eden

17 Burial (Burial, cremation, or removal) (b) Date then Aug 24, 1945
(c) Cemetery or crematory Mt Calvo
Location Brooklandville

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams

AUG 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16- 1945, at 1:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhoea

Due to

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-19-45

G31734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/21

G31734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Perkins Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hazel Wyatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife ROBERT L. WYATT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-22-19

8. AGE: Years	Months	Days	If less than one day
26	3	25	hr. min.

9. Birthplace ACCOMAC CO., VA.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name JOHN DUFFY
13. Birthplace VA

MOTHER
14. Maiden Name AMY WASHINGTON
15. Birthplace VA

16 (a) Informant AMY WASHINGTON
(b) Address 614 PERKINS AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 45 (month) (day) (year)
(c) Cemetery or crematory ACCOMAC CO VA
Location VA

18 (a) Funeral director Ethyl O Wilson
(b) Address 1008 Huntingtown Ave Huntingtown Maryland

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1945, at 4:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Respiratory Failure
Shock
Due to Spinal Anesthetic (Pontocain)
Other Conditions Acute Appendicitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W. B. McNally M.D. Medical Examiner.
Date signed 8/18/45

G31735 — 478730 — G31735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Donald Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-45

8. AGE: Years	Months	Days	If less than one day
	3 4	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Watkins
FATHER — 13. Birthplace Va.

MOTHER — 14. Maiden Name Marie Singletary
MOTHER — 15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22nd 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calv.
Location Brookland Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) (Date) rec'd by registrar Registrar

AUG 24 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 19 1945 at 9, P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 13 1945 to Aug - 19 1945, and that I last saw him alive on Aug - 19 1945.

Immediate cause of death: Cerebral Thrombosis — Duration

Due to Dehydration

Due to Diarrhea

Other Conditions Acidosis, Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Everett Barton M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/20/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G31736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 W. Barre St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)
(d) Street No. 703 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Pluhar PLUHAR

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Rosa L. Pluhar (Filekenstein) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business Maryland Dress Co.

FATHER
12. Name James Pluhar
13. Birthplace Bohemia

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. John J. Pluhar
(b) Address 3430 Elmora Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ryan
(b) Address 5305 Harford Road

19 AUG 21 1945 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 45 19, at 10 45 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Squamous Carcinoma of Esophagus and metastases Esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallen M.D.
Medical Examiner.
Date signed August 21, 1945.

Huntington Williams, M.D.

G31737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1920

G31737 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Especially important. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elliott B. Waddy

3 (b) If veteran, name war None | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 10, 1906

8. AGE: Years	Months	Days	If less than one day
39	3	9	hr. min.

9. Birthplace Virginia (town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business Railroad

FATHER
12. Name Chas B Waddy
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Kent
15. Birthplace Virginia

16 (a) Informant Mrs Chas B Waddy
(b) Address 15 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-20 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Hopewell Ave

18 (a) Funeral director Thos J. Emory
(b) Address Hollins & Gilmore

(a) Date rec'd by Registrar 8-21-20 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1920, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1920 to Aug 19 1920 and that I last saw him alive on Aug 18 1920.

Immediate cause of death	Duration
Cardiac decompensation	4 days
Due to Mitral Stenosis	
Due to	
Other Conditions Epilepsy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Chas A Parker

23. Signature
Address 2145 W Balt St Date signed 8/21/20 M.D.

VS 150

Huntington Williams, M.D.

FL - 95254 G31738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631738

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 796 Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1910

8. AGE: Years 35 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris Price
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary Hawkins
15. Birthplace Balto, Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) AUG 21 1945 (b) Huntingtown Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6, 1945 to Aug 18 1945, and that I last saw her alive on Aug. 16 1945.

Immediate cause of death: Cerebral thrombosis — Brain tumor

Duration: ? ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jennings M. D.
Address Baltimore City Hosp. Date signed 8-18-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31739

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1927 G31739 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 745 W Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 745 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Anne Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Frank Holley.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1862

8. AGE: Years 82 | Months 10 | Days | If less than one day ____ hr. ____ min.

9. Birthplace St. Marys Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John Richard Barnes
(b) Address 745 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 '45 (month) (day) (year)

(c) Cemetery or crematory Sts. Peters
Location

18 (a) Funeral director Mrs Kate A Wallman
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to Aug 19 1945.
and that I last saw h[illegible] alive on Aug 19 1945.

Immediate cause of death Arteriosclerosis
Due to Cerebral Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 24 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature For R. J. R. Davis - Howard J. Nuttycombe, M.D.
Address Date signed 8/27/45 M. D.

VS 150

G31740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G31740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edmondson City (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby girl Atkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1945

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name George Atkins
13. Birthplace Ky.

MOTHER
14. Maiden name Cora Bears
15. Birthplace Kentucky

16 (a) Informant George Atkins
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director H. C. Hughbottom
(b) Address Ellicott City Md

19 (a) Date received by registrar 8-21-1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1945, at 5:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1945, to 8-20 1945, and that I last saw her alive on 8-20-1945

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton T. Hall Jr. M.D.
Address St Agnes Hosp. Date signed 8/20/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31741

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31741

Registered No. 61676

CERTIFICATE OF DEATH 52R

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Dr. and 31st Street
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo29da
(e) Length of stay in Baltimore (yrs., mos., or days) 2mo29da

2. USUAL RESIDENCE OF DECEASED:
(a) State R. I. (b) County
(c) City or town Providence
(If outside city or town limits, write RURAL and give town)
(d) Street No. 60 Vandewater Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]-14-1361

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1884

8. AGE: Years	Months	Days	If less than one day
61	4	5	hr. min.

9. Birthplace Brooklyn, New York
(Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business Seafaring

FATHER
12. Name Emil Anderson
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-45 (month) (day) (year)
(c) Cemetery or crematory Highland Park
Location Providence R. I.

18 (a) Funeral director Geo. Lee & Son
(b) Address 4644 York Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1945, at 7:25p M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30, 1945, to Aug. 19, 1945, and that I last saw him alive on Aug. 19, 1945

Immediate cause of death: Carcinoma of bladder with metastasis to lungs and left scapula. Arteriosclerotic heart disease with myocardial degeneration. Hydronephrosis bilateral — Duration: More than 1 year

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 14, 1945

Major findings of operation: Suprapubic cystotomy with drainage, Implantation of gold radon tubes into bladder

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital, Baltimore, Md. Date signed 8/20/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G31742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

✓ G31742 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 Baltimore Md.
(c) Hospital or institution: St Joseph's Hospital 9/10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin B. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	none	Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	4	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Street Cleaner
11. Industry or business City of Balto.

FATHER
12. Name Joseph Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Mary (?)
15. Birthplace Md.

16 (a) Informant Harry J. Smith
(b) Address 1814 E. Oliver Street

17 (a) Burial (b) Date thereof 8/24/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director Wilkins-Cook, Inc.
(b) Address 1317 St. Paul Street

19 (a) Date received AUG 22 1945 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection or Inquiry thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions Dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/20/45 3 P. M.
(b) Where did injury occur? 1501 N. Bethel St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Hanging from rafters.

23. Signature Howard J. Rhoden M.D.
Medical Examiner.
Date signed 8/21/45

X

631743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 631743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Parkmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Parkmont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Maude Ripyard

3 (b) If veteran, name war —

3 (c) Social Security Account No. [illegible]

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1878

8. AGE: Years 67 Months 5 Days 3 If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Rypard
13. Birthplace unknown

MOTHER
14. Maiden Name Prudie G ?
15. Birthplace unknown

16 (a) Informant J Calvin Garland
(b) Address 4502 Parkmont Ave

17 (a) London (Burial, cremation, or removal) (b) Date thereof Aug 24 45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 (a) AUG 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 8/21 1945
and that I last saw h. alive on 8/20 1945

Immediate cause of death Coronary Occlusion — Duration 24 hrs

Due to Arteriosclerosis — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2020 E. Clarks Date signed 8/24/45

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G31744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Booth St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Booth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Lehmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Karl G Lehmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1877

8. AGE: Years 68 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Eichhorst
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Karl G Lehmann
(b) Address 2022 Booth St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location

18 (a) Funeral director Wm Loh Jr
(b) Address 1204 Pont St

19 (a) AUG 22 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945 at 10 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1945 to Aug 21 1945; that I last saw him alive on Aug 21 1945.

Immediate cause of death Chronic Cardiac Disease — Duration 5 yrs.

Due to

Due to

Other Conditions Cerebral Hem

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest W. Kahn
Address 1730 Pont St Date signed 8/22/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31745

EVA M. Meiser

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31745

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2647 Francis
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 Francis
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Mae Meiser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife William F. Meiser
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept 17 1892

8. AGE: Years	Months	Days	If less than one day
52	11	3	hr. min.

9. Birthplace York Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name William Henry Edwards
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Keeny
15. Birthplace Virginia

16 (a) Informant Miss Hilda Beatty (daughter)
(b) Address 2647 Francis St

17 (a) Burial (b) Date thereof 8/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) AUG 22 1945 (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1945, at 705 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1945, to Aug 20 1945, and that I last saw h[er] alive on Aug 20 1945.

Immediate cause of death

Duration
8/19/45

Cerebral Hemorrage

Due to Chr. Myocarditis | 1939

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Janet Brown

Address 1663 Montford Date signed 8/22/45

X

G31746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31746

JO #94802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Low ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Wesley Jolley or Jolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1879 ?

8. AGE: Years	Months	Days	If less than one day
66?	3 ?	2 ?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Preacher
11. Industry or business

FATHER
12. Name Josiah
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-21-45 (month) (day) (year)
(c) Cemetery or crematory Orlentus Memorial Pk
Location Baltimore Md

18 (a) Funeral director Archibald A. Hadden
(b) Address 2101 Mc Culloh St

Filed AUG 22 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1945, at 8:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1945, to Aug. 17, 1945, and that I last saw him alive on Aug. 16, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Embolus from heart ? —

Due to Auricular fibrillation ? —

Other Conditions Coronary Sclerosis & Hypertension —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Haviland M. D.
Address [illegible] Date signed 8/12/45

VS 150

X

G31747

1 Copy

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

125B

G31747

Registered No. 63378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Rural RFD #1 Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Peltz

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-5646

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1896

8. AGE: Years	Months	Days	If less than one day
48	7	28	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Chief mate
11. Industry or business Seafaring

FATHER
12. Name Anton Peltz
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W Singleton
(b) Address Glen Burnie Md

19 (a) (b)
AUG 22 1945 Huntington Williams, MD

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 20 1945 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 14 1945, to Aug. 20 1945, and that I last saw him alive on Aug. 20 1945.

Immediate cause of death Nephrosis, acute with terminal uremia and right sided heart failure; Hepatitis, acute — Duration: 1 month

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 8/20/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31748

JL - 16183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G31748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mo. 10 da. 29
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 E. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nathaniel Turner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
72 ?	?	?	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant D. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 22 1945 (Date received by registrar) Nathaniel Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug. 6, 1945 19 , at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1932 Aug. 6 1945 and that I last saw him alive on Aug. 6, 1945

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to cerebral arteriosclerosis	
Due to	
Other Conditions uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 8/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2909

X

31749

HEP #90564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Garland Ridgeway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1909

8. AGE: Years	Months	Days	If less than one day
36	2	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Orvey Ridgeway
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Norris
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

UNIVERSITY MEDICAL SCHOOL AUG 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 22 1945 (Filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1945, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8, 1944, to Aug. 8, 1945, and that I last saw him alive on Aug. 8, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 8/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

2908

G31750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G31750 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Eldamont St
(c) Hospital or institution: Franklatta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N. Eldamont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russ Balser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: JOSHUA S. BALSER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Pith (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George -
13. Birthplace Pith

MOTHER
14. Maiden Name Ada -
15. Birthplace Pith

16 (a) Informant Nathan R. Balser
(b) Address 331 W. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 22 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1945 at 10 57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1945 to Aug 20 1945 and that I last saw her alive on Aug 20 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days.
Due to: Malignant Hypertension, Cardiac Hypertrophy	5-10 yrs.
Due to: same	
Other Conditions: Diabetes Mellitus, Chronic Pulmonary Tbc - Quiescent	-

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Newton Cooper M.D.
Address 1701 Eutaw Place Date signed 8/24/45

95c

Please write plainly, with pen and ink, using only information known to the undersigned. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G31751

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 40
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Mc Phail St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Beavers

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M. 1 day
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-45

8. AGE: Years | Months | Days | If less than one day: 19 hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Audrey Beavers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Trueman Beavers
15. Birthplace Baltimore, Md.

16 (a) Informant Audrey Beavers
(b) Address 108 Mc Phail St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 21 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 22 1945 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1945, at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1945 to 8-20 1945, and that I last saw him alive on 8-20 1945.

Immediate cause of death: Respiratory Failure — Duration: 1 day

Due to: Prematurity (36 wks - 4 pounds)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Caines M. D.
Address Franklin Square Hosp. Date signed 8-21-45

2911

631752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 159

Registered No. 631752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Lottsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bramble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-9-45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Bramble
13. Birthplace Va.

MOTHER
14. Maiden Name Frances Lewis
15. Birthplace Md

16 (a) Informant Rescinded.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL AUG 21 1945

18. (a) Funeral director Commissioner of Health
(b) Address

19 AUG 22 1945 (Date received by registrar) [illegible] Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1945 at 8 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Aug 12 1945 and that I last saw him alive on Aug 12 1945.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Everitt Batson
Assistant Resident M.D.
Address Johns Hopkins Hospital Date signed 8/12/45

VS 150

2910

X

G31753

JO #95487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31753

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Boy Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White m

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14, 1945

8. AGE: Years | Months | Days: -1- | If less than one day: 4 hr. 35 min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name: Cecil Hughes

13. Birthplace: Virginia

14. Maiden Name: Margaret Aikens

15. Birthplace: Virginia

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
8 00 PM
(c) Cemetery or crematory B.C.H.
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) AUG 22 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 15, 1945, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14, 1945, to Aug. 15, 1945, and that I last saw him alive on Aug. 15, 1945.

Immediate cause of death: Bronchopneumonia, Aspiration Pneumonia — Interval between onset and death

Due to: Prematurity

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: S. Thies, M.D.
Address: Balt City Hosp. Balto Md Date signed 8/16/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31754

JO #95459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

✓ G31754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 10 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Middleton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1945.

8. AGE: Years	Months	Days	If less than one day
---	---	---	1 hr. 10 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name Robert Smith
13. Birthplace Maryland
14. Maiden Name Frances Middleton
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 8-20-45 (month) (day) (year)
(c) Cemetery or crematory B. C. H. Hosp. Location 4940 Eastern ave.

18 (a) Funeral director
(b) Address

19 (a) Date Received AUG 22 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15, 1945, to Aug. 15, 1945, and that I last saw her alive on Aug. 15, 1945.

Immediate cause of death	Duration
Asphyxia ?	
Cerebral Hemorrhage ?	
Due to Difficult Breech Extraction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Balt. City Hosp. Balt. Md. Date signed 8/16/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

Registered No. G31755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Grindalds ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy V. Burhouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Talmadge D. Burkhouse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12. 1924

8. AGE: Years	Months	Days	If less than one day
21	6	7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Social Security Board

FATHER
12. Name Herman A. Nebstreit
13. Birthplace Germany

MOTHER
14. Maiden Name Rosella Wisner
15. Birthplace Balto. Md

16 (a) Informant Herman A. Nebstreit
(b) Address 706 Devonshire Road

17 (a) Burial (b) Date thereof Aug 23. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) (b)
(Entered by registrar) Registrar

AUG 22 1945 Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21-1945, at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/21/45 at 12 M.
(b) Where did injury occur? 1932 Grindalds Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Kitchen stove - gas burners.

23. Signature Herman J. Nebstreit M.D.
Medical Examiner.
Date signed 8-21-45

G31756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G31756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Stoneleigh
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7118 Wardenman Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Kaufholz

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia Catherine Kaufholz

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 3, 1900

8. AGE: Years 45 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Designing Engineer

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: Ferdinand Kaufholz
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Dora Tilsen
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. William Kaufmann
(b) Address: 7118 Wardenman Road, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (b) Washington, D.C.

AUG 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1945 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17/45 19... to 8/21/1945.
and that I last saw him alive on 8/21/1945.

Immediate cause of death: Carcinomatosis — Duration: 3 mo. +

Due to: Carcinoma of Stomach — 3 mo +

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Robert L. Allen M. D.
Address: Union Memorial Hospital Date signed 8/21/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G31757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Hazel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Demon Charron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/1[illegible]

8. AGE: Years	Months	Days	If less than one day
34	5	23	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business Sewage

FATHER
12. Name Demon Charron
13. Birthplace Mass MASS.

MOTHER
14. Maiden Name Florence Parish
15. Birthplace Md

16 (a) Informant Mrs. Florence Charron
(b) Address 2025 W Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Edward Foulkrod
(b) Address 2359 Work Blvd

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 8-21-45

G31758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

Registered No. G31758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 Ward St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Ingram

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	negro	married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Pamplin Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Hunter
13. Birthplace Va

MOTHER
14. Maiden Name Rose Hunter(?)
15. Birthplace Va

16 (a) Informant Jessie Ingram
(b) Address 1343 Ward St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)
(c) Cemetery or crematory
Location Farmville, Va

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brant Ley Ave

AUG 22 1945 (b) Huntington Williams Md
(Local Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1945 at 1:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 8/20 1945 and that I last saw her alive on 8/20 1945 4:30 P

Immediate cause of death	Duration
Acute Yellow Atrophy	7 Days
Due to ?	
Due to	
Other Conditions Pulmonary Congestion Terminal	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. T. Kurland M D
Address University Hospital Date signed 8/20/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Kurland X

631759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 631759

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Rd

(c) Hospital or institution: Ashburton Rd

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3520 Hilton Rd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Annie Katherine Burgess

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1867

8. AGE: Years	Months	Days	If less than one day
78	0	5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home worker

11. Industry or business Home

FATHER 12. Name Thomas Burgess

13. Birthplace Sussex County Del.

MOTHER 14. Maiden Name Mary Bruce

15. Birthplace York Pa.

16 (a) Informant Mrs Katherine A Jackett

(b) Address 1523 Sheffield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 '45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund D. Conklin Co.

(b) Address 2222 E. Eager St.

19 AUG 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1945 to Aug 18 1945 and that I last saw h[illegible] alive on Aug 18 1945.

Immediate cause of death	Interval between onset and death
Respiratory Failure	
Due to Uterine Carcinoma	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence Aug 20, 1945 at 8:45 P.M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Charles F. O'Donnell M.D.

Address 7301 York Rd Date signed 8/22/45

VS 150

G31760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

G31760 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin A. Lee Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1943

8. AGE: Years | Months 11 | Days | If less than one day hr. min.

9. Birthplace Greenville, S. Carolina (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Otis Foster

13. Birthplace Greenville, S. Carolina

MOTHER 14. Maiden Name Mary Smith

15. Birthplace Greenville, S. Carolina

16 (a) Informant Mrs. Bess

(b) Address 2416 Madison Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Aug. 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Greenville, S.C. Family Lot

Location Burlington Hill, S.C.

18 (a) Funeral director Mrs. Lafayette H. Holland

(b) Address 1601 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 22 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1945, at 6:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymico-lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Meeseri M.D. Medical Examiner.
Date signed 8-20-45

G31761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31761

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 Warren Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Warren Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth C. Miskimon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Andrew J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17 1864

8. AGE: Years	Months	Days	If less than one day
81	3	3	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Robert McClean
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Watchman
15. Birthplace Unknown

16 (a) Informant Mrs C. A. McClean
(b) Address 43 E. Seematta St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F. Henry Inc
(b) Address 714 Light St.

19 (a) AUG 22 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17, 1945 to 8/20/ 1945 and that I last saw her alive on 8/19/ 1945

Immediate cause of death: Hypertensive cardio vascular disease. — Duration: 5 mos. 3 da.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Henry Deale M. D.
Address 1226 Hanover St. Date signed 8/21/ 1945.

VS 150

G31762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31762 / 1572

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N. Mount St
(c) Hospital or institution: Presidential Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-45

8. AGE: Years	Months	Days	If less than one day
0	0	0	18 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arie Davis
13. Birthplace Hamlet, N.C.

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace St. Charles, S.C.

16 (a) Informant Arie Davis
(b) Address 704 N. Mount St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Left for Pathological Surgery
Location

18 (a) Funeral director
(b) Address

AUG 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-1945 to 8-14-1945 and that I last saw h-er alive on 8-14-1945

Immediate cause of death
Prematurity
Complications & meningocele
Due to Microcephalus
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Welcome M. D.
Address 1131 Harlem Ave Date signed 8/14/45

G31763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31763
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklandville (If outside city or town limits, write RURAL and give town)
(d) Street No. Valley Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Harry Percy Lucas (Anna Edgar Lucas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. Harry Percy Lucas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1883

8. AGE: Years	Months	Days	If less than one day
62	5	17	hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. George E. Edgar
13. Birthplace Md

MOTHER
14. Maiden Name Alice Slater
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Harry Percy Lucas
(b) Address Valley Rd., Brooklandville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 /45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry N. Jenkins Sons Co.
(b) Address McCulloh & Richard Sts

19 (a) AUG 22 1945 (Date received by registrar) (b) Huntingtown, Williamstown, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/45 19 , at 6:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20/ 1945, to 8/20/ 1945, and that I last saw her alive on 8/20/ 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hours
Due to Arterial Hypertension	3 years
Due to Cardio Vascular Hypertension Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. W. Hodges M. D.
Address 3301 Guilford Ave, Baltimore Md. 8/20/45

Insert age is especially important. Physicians: please write the causes of death clearly and legibly.

31764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

Registered No. 631764

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Perry Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Fourth St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John William Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Dora R. Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1879

8. AGE: Years 66 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Cecil Co., Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Government

FATHER
12. Name James F. Ward
13. Birthplace Cecil Co., Md

MOTHER
14. Maiden Name Sarah C. Alexander
15. Birthplace Cecil Co., Md

16 (a) Informant Dora R. Ward
(b) Address 1140 Fourth St., Perry Point, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25, 1945 (month) (day) (year)

(c) Cemetery or crematory Friends
Location Elkton, Cecil Co., Md

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

19 (a) AUG 29 1945 (Date rec'd by local reg.) (b) Courtesy for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1945 at 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1945 to 8-22 1945 and that I last saw him alive on 8-22 1945

Immediate cause of death	Duration
Atelectasis	
terminal bronchial pneumonia	
Due to Intestinal obstruction (Ileum)	
Due to Adhesions around gall bladder (Cholelithiasis & cholecystitis)	
Other Conditions Arteriosclerosis of kidneys	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Md. Gen. Hosp. Date signed 8/29/45 M. D.

126

VS 150

G31765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G31765

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Mi5ton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Basto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Mi5ton Ave, (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Est5Ss M. Stadter

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Lawrence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1876

8. AGE: Years 69 | Months - | Days | If less than one day hr. mjn.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Howard
13. Birthplace

MOTHER 14. Maiden Name Mira
15. Birthplace

16 (a) Informant Mary Coyne
(b) Address 4 N. Mi5ton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)
(c) Cemetery or crematory N. Cemetery
Location Old Frederick Rd.

18 (a) Funeral director H. W. & D. Applefield Sons
(b) Address Lombard - Ann St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 22 1945

VS No 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1945 to 19
and that I last saw h alive on 8-18-1945.

Immediate cause of death Heart Insufficiency

Due to Myocardial degeneration

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Many years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Transgott M. D.
Address 11 E. Chase St. Date signed 8-24-45

G31766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31766 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 S. Ann St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst, (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 S. Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Naumann

3 (b) If veteran, name war No

3 (c) Social Security Account No. 160-03-3537

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1876

8. AGE: Years 69 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Peter Naumann

13. Birthplace Germany

MOTHER 14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant Paula Walter

(b) Address 1524 Robinwood Rd.

17 (a) Bur. (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)

(c) Cemetery or crematory Second Ger. Luth

Location German Hill Rd.

18 (a) Funeral director M. W. E. Oppelt Sons

(b) Address 600-602 Ann St.

19 (a) (Date received by registrar) (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945, at 5:9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 21 1945 and that I last saw [illegible] alive on Aug 21 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon, M.D.

Address 89 S. Paca Date signed 8/25/45

VS 150

G31767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G31767
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 N. Spring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Campbell Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12th 1920

8. AGE: Years	Months	Days	If less than one day
24	8	8	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Campbell Sr.
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Mary Carmish
15. Birthplace Md.

16 (a) Informant Robert Campbell Sr
(b) Address 731 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Byron Francis & Wright
(b) Address 721 Pasquith St

19 (date) 1945 (Signature of registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945, at 8:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.
Accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-20-45 4:16 P M. 22/1
(b) Where did injury occur? Pier #7, Light St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Painting a pier & fell

23. Signature Howard J. Devereux M.D.
Medical Examiner.
Date signed 9-21-45

VS 151

G31768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Ruckert Avenue (RUECKERT)
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Clarksburg, (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 East Pike (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clyde C. Cool

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Carrie nee Weimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1889

8. AGE: Years	Months	Days	If less than one day
55	11 10	23	hr. min.

9. Birthplace Tetor, W. Va. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Glenn L. Martin

FATHER
12. Name John J. Cool
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ellen Strader
15. Birthplace Tetor W. Va.

16 (a) Informant Mrs. Pauline Carew
(b) Address 2816 Ruckert Avenue

17 (a) Burial Transit (Burial, cremation, or removal) (b) Date thereof 8-22-45 (month) (day) (year)
(c) Cemetery or crematory Rogers Cemetery
Location Tetor, W. Va.

18 (a) Funeral director Leonard J. Ruck
(b) Address 530 Huntington Williams, Mgr.

AUG 22 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 45, at 6P. M

21. I certify that I took charge of the remains described above, held an Inquest & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage, Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 8-22-45

VS 151

G31798568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G31769

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State U. S. (b) County
(c) City or town Woodside
(If outside city or town limits, write RURAL and give town)
(d) Street No. 448 4-2-6 & rd Lt - (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Mercedes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, '42

8. AGE: Years	Months	Days	If less than one day
2	11	23	hr. min.

9. Birthplace Near York - (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER — 12. Name	Phillips Mercedes
FATHER — 13. Birthplace	Near York -
MOTHER — 14. Maiden Name	Betty Ferds -
MOTHER — 15. Birthplace	Italy -

16 (a) Informant Ferds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22/45 (month) (day) (year)
(c) Cemetery or crematory Woodside
Location Long Island

18 (a) Funeral director John O. Mitchell's Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 23 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1945 at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945 to Aug 22 1945 and that I last saw [illegible] alive on Aug 22 1945

Immediate cause of death Cardiac failure + respiratory arrest. — Duration

Due to Pulmonary edema

Due to

Other Conditions Tetralogy of Fallot

(Include pregnancy within 3 months of death)

Date of operation 8-21-45

Major findings of operation: Pulmonary stenosis - foramen ovale patent - [illegible] of auricular septum

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jolyon A. Elder, Jr. M.D.
Address Johns Hopkins Date signed 8-22

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G31770 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2800 Evergreen Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Evergreen Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH DAWSON VAIL

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred B. Vail

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1863

8. AGE: Years 81 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Brooklyn, N. Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas G. Austin
13. Birthplace Scotland

MOTHER
14. Maiden Name Ann Mellen
15. Birthplace Scotland

16 (a) Informant Mr. Fred B. Vail
(b) Address 2800 Evergreen Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Riverhead, Long Island, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)

AUG 28 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1945, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1945 to Aug 21 1945, and that I last saw her alive on Aug 21, 1945.

Immediate cause of death: Myocardial insufficiency — Duration

Due to: Chronic

Due to: Myocarditis

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Hunter

Address 1125 St Paul St Date signed 8/24/45

X

Please write plainly with pen or pencil. Do not use ink. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Farrington
2524 Fr. Park Ave.
9-10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G31771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 W 34th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Baker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife James Baker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1853

8. AGE: Years	Months	Days	If less than one day
92	-	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Joseph M. Snyder.
(b) Address 903 W 34th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville

18 (a) Funeral director Edmond Donovan
(b) Address 3615-17 Chestnut Ave.

19 AUG 23 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1945 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 - 1945, to Aug. 21 1945, and that I last saw h[illegible] alive on Aug. 21 1945.

Immediate cause of death	Duration
Bronchopneumonia	7 days.
Due to Myocarditis chronic	unknown
Due to Nephritis, chronic	unknown
Other Conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Stinton M. D.
Address 1500 Eutaw Pl. Date signed Aug. 23/45

VS 150

Please write plainly, with pen or indelible pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31772

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31772 ✓ Registered No. 122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union Mem. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Fawcett St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Herman.
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-05-27[illegible]
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. married.
6 (b) Name of husband or wife Eva E Herman
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Aug 12, 1891
8. AGE: Years 54 | Months - | Days 10 | If less than one day ____ hr. ____ min.
9. Birthplace Johnstown Pa (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Domino Chemical Co
FATHER 12. Name Michael A. Herrman
13. Birthplace Md.
MOTHER 14. Maiden Name Mary L Lavey.
15. Birthplace Md
16 (a) Informant Eva E Herman.
(b) Address 424 Fawcett St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 1945 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden
18 (a) Funeral director Chenoweth & Donovan
(b) Address 745-17 Cheastnut Ave.
19 (a) AUG 23 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1945, at 8 55 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945 to Aug 22 1945 and that I last saw him alive on Aug 22 1945

Immediate cause of death Pulmonary embolism — Duration 30 minutes
Due to Post-operative, umbilical hernia repair
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 7-27-45
Major findings of operation: umbilical hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S. W. Lippincott, Jr. M. D.
Address Union Memorial Date signed 8-22-45

VS 150

Please write clearly, using ink. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

G31773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N. Chester St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(c) Street No. 24 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID HAMET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Eva -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
70				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER
12. Name -
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Swedstein
(b) Address 24 N. Chester

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Peirce Inc
(b) Address 1439 E. Balto St

19 AUG 23 1945 Huntington Williamsport, Md
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 - 1945, at 11 38 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 22 1945 and that I last saw h living alive on Aug 22 1945.

Immediate cause of death Aorta Cerebral Hemorrhage — Duration

Due to Ch. Hypertention

Due to Coma & Uremia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Arsquith St Date signed 8/23/45

X

FEMALE WHITE FUNERAL, WITH EMBALMING INS. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

631774 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2914 Ulman Ave

(c) Hospital or institution: Sinai Hos. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2914 Ulman ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HYMAN Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Minna

15. Birthplace Russia

16 (a) Informant Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto & Conkling Sts

18 (a) Funeral director Jack Levin

(b) Address 1439 E Baltimore St

19 (a) AUG 23 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1945, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1945 to 8-22 1945, and that I last saw him alive on 8-22 1945

Immediate cause of death	Duration
Acute Cerebral Failure	
Due to Coronary Infection	
Due to Arteriosclerotic cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jacob L Rosenthal M. D.

Address Sinai Hospital Date signed 8-23-45

VS 150

Occ'n X

G31775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lyman Park Dr. and 31st Street
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Whitestone
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ENOCH JAMES CONQUEST

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 227-09-8436

4. Sex: Male

5. Color or race: col.

6 (a) Single, married, widowed, or divorced: mar.

6 (b) Name of husband or wife: Mamie Cottman

6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1897

8. AGE: Years: 47 | Months: 7 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Whitestone, Virginia
(Town, county, and state)

10. Usual Occupation: Fisherman

11. Industry or business: Fishing

FATHER
12. Name: Levy Conquest
13. Birthplace: Accomac County

MOTHER
14. Maiden Name: Millie Fauntleroy
15. Birthplace: Whitestone, Virginia

16 (a) Informant: Records-US Marine Hospital
(b) Address: Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/45 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: A. A. County, Md.

18 (a) Funeral director: Charles H. Cooper
(b) Address: 512 N. Carrollton Ave.

AUG 23 1945

Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945, at 1:20a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1945, to Aug 20, 1945, and that I last saw him alive on Aug. 20, 1945.

Immediate cause of death: Hypertensive cardio-vascular disease — Duration: 3 Mos.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: No operation

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John H. Williams M. D.

Address: US Marine Hospital, Baltimore, Md. Date signed 8/20/45

VS 180

~ correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G31776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: John Hopkins Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Myra Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Whitney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1880

8. AGE: Years	Months	Days	If less than one day
64	7	8	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Henry Whitney
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Balto, Md.

16 (a) Informant Mr Appler
(b) Address 2218 Myra St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location E North & Lombard Sts.

18 (a) Funeral director D. J. Covington
(b) Address 21 W 23 St.

(c) AUG 23 1945 Huntington Williams Registrar
(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 45 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation.

Due to Illuminating Gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-22-45 at 6 A. M.
(b) Where did injury occur? 2216 Myra Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury 3 burners on top turned

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed August 22 1945.

G31777

G31777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 4747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2837 Booker Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 Booker Dr. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Booker

3 (a) FULL NAME Kelley Dail

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Widowed

6 (b) Name of husband or wife Leona Dail
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1866

8. AGE: Years	Months	Days	If less than one day
79	1	5	— hr. — min.

9. Birthplace Hertford N.C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER / FATHER
12. Name James Dail
13. Birthplace Hertford N.C.
14. Maiden Name Mary
15. Birthplace Hertford N.C.

16 (a) Informant Zola M. Dail
(b) Address 2837 Booker Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md. Halethorp

18 (a) Funeral director Adolph Halethorp
(b) Address 918 Druid Hill Ave.

(c) AUG 23 1945 rec'd by registrar Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1945, at 5.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to Aug 21 1945, and that I last saw him alive on 8/21 1945.

Immediate cause of death Arterio-sclerotic heart disease.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold B. Lightholder M. D.
Address 501 Cherry Hill Rd. Date signed 8/27/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G31778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1154 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Dolores A. Raymond Lucchesi

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Samuel Lucchesi

6 (c) If alive, give age years

7. Birth date of deceased (mo.): Dec 25 1917

8. AGE: Years 27 | Months 7 | Days 27 | If less than one day: hr. min.

9. Birthplace: Michigan
(Town, county, and state)

10. Usual Occupation: Singer

11. Industry or business: Two O'Clock Club

FATHER
12. Name: Mickael Raymond
13. Birthplace: Italy

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Samuel Lucchesi
(b) Address: 1154 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) AUG 23 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1945, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1945 to 8/22 1945, and that I last saw h.er alive on 8/22 1945

Immediate cause of death: Cachexia — Duration

Due to: Carcinomatosis

Due to: Ovarian cystadenoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. W. Maynard M. D.
Address: Md. Sinai Hosp Date signed 8/23/45

correct age in especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G31779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G31779 Registered No. 137a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calver + Saratoga Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22d.
(e) Length of stay in Baltimore (yrs., mos., or days) 22d.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County —
(c) City or town Weston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Center Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME James Aloysius Tierney
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife: Not available
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr 2 1867

8. AGE: Years	Months	Days	If less than one day
78	4	20	— hr. — min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name Patrick Tierney
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mulvey
15. Birthplace Ireland

16 (a) Informant —
(b) Address —

17 (a) Removal (b) Date thereof 8/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Weston
Location Weston W. Va.
18 (a) Funeral director Fellows Lynch Inc
(b) Address 13 W Pratt St
19 (a) Aug 23 1945 (b) Huntington Williamson, W. Va.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1945, at 305 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1945, to 8/22 1945 and that I last saw him alive on 8/22 1945.

Immediate cause of death	Duration
Uremia	
Due to Benign Prostatic Hypertrophy	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Alex B Tully Jr M.D.
Address Mercy Hosp. Date signed 8/22

X

VS 150

ALLEN ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31780

G31780 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 S. Hall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 S. Hall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Allen

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Thomas H. Allen.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1892

8. AGE: Years	Months	Days	If less than one day
52	11	27	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business Home.

FATHER
12. Name Wm. Carey
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Long
15. Birthplace England

16. (a) Informant family
(b) Address 17 S. Hall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven.
Location Glen Burnie Md.

18 (a) Funeral director J. H. McCarley
(b) Address Glen Burnie Md.

19 AUG 23 1945 (b) Registrar for Williams, M.D.
(Date received by Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1940, to Aug 21 1945, and that I last saw h[er] alive on Aug 20 1945.

Immediate cause of death Generalized Tuberculosis — Duration 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. H. H. Parramore M.D.
Address 436 E. Fort Ave. Date signed 8/23/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

G31781

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Karns KARNS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19/65

8. AGE: Years | Months: 34 | Days: 3 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Raf. Karns
13. Birthplace ?

MOTHER
14. Maiden Name Jessie ?
15. Birthplace ?

16 (a) Informant Raf. Karns
(b) Address 1012 S Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Leasmaker
(b) Address 602 Wash. Blvd

19 (a) (b) Date rec'd by registrar Huntington Williams, Registrar
AUG 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uppr Respiratory Infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masseno M.D. Medical Examiner.
Date signed August 23, 1945.

3037 O'Donnell 11 G31782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G31782 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 S Lusley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 S Lusley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew M. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~ Married

6 (b) Name of husband or ~~wife~~ Eugene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1880

8. AGE: Years 65 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Norway
(Town, county, and state)

10. Usual Occupation

11. Industry or business Machines

FATHER
12. Name Johannes Anderson
13. Birthplace Norway

MOTHER
14. Maiden Name Caroline Haugland
15. Birthplace Norway

16 (a) Informant Eugene Anderson
(b) Address 26 S Lusley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 23 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John C. Horan
(b) Address 3000 E Baltimore St.

19 (a) AUG 22 1945 (b) Registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 19 45 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1945, to Aug. 21, 1945, and that I last saw him dead on Aug. 21, 1945.

Immediate cause of death	Duration
Myocardial insufficiency	?
Due to chronic valvular heart disease	?
Due to Arterio-sclerosis	?
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. B. Bronushas, M.D.
Address 3037 O'Donnell St. Date signed 8-22-45

Howard J. Clemens, M.D. 93

VS 150

Please print, type, or write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Any error or omission should be corrected by supplement. The correct age is especially important.

G31783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31783 Registered No. 1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Long
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Kenneth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Sullivan Redifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 - 1909

8. AGE: Years	Months	Days	If less than one day
35	9 11	14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Redifer
13. Birthplace

MOTHER
14. Maiden Name Margaret Boyle
15. Birthplace Ireland

16 (a) Informant Margaret Redifer
(b) Address 426 Kenneth Ave

17 (a) Burial (b) Date thereof Aug 25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3600 Baltimore St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21- 1945 at 9 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from; natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage (Internal)

Due to Ruptured esophageal varices + Cirrhosis of liver.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Sturham M.D.
Medical Examiner.
Date signed 8/22/45

VS 151

G31784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G31784

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore Catonsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1219 Maiden Choice Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Cobb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace BALTO MD

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Leon COBB

13. Birthplace MARYLAND

MOTHER 14. Maiden Name Helen Fehler

15. Birthplace Maryland

16 (a) Informant HOSPITAL RECORD

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-45 (month) (day) (year)

(c) Cemetery or crematory METHODIST CEM

Location ABINGDON MD

18 (a) Funeral director Wm. Chas. A. J. Rhide

(b) Address 3327 Edmondson

19 (a) AUG 23 1945 (Date received by registrar) Huntington Willis Rhide, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 19 45 at 5:22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/xx 19 45 to 8/23 19 45

and that I last saw h alive on 8/22 19 45

Immediate cause of death (a) Prematurity

(b) Brain hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury —

(f) Signature H. W. Elliott Jr

Address St Agnes Hosp Date signed 8/23/45

VS 150

G31785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31785

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2736 BAKER STREET

(c) Hospital or institution: HOME

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 24 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 2736 BAKER STREET (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH BELL HORTON

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife ISAAC HORTON

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JULY 2, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	16	✓ hr. ✓ min.

9. Birthplace LOARTOWN MARYLAND (Town, county and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER

12. Name JAMES A. HENRY

13. Birthplace UNKNOWN

MOTHER

14. Maiden Name LYDIA E. "UNKNOWN"

15. Birthplace UNKNOWN

16 (a) Informant MRS. ROBERT L. HORTON

(b) Address 2736 BAKER STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)

(c) Cemetery or crematory LOARTOWN

Location FROSTBURG, MD.

18 (a) Funeral director G. LESTER WEBER

(b) Address 2603 EDMONDSON AVE.

19 (c) [illegible] 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1945 at 2:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to Aug 23 1945 and that I last saw her alive on Aug. 22 1945.

Immediate cause of death Carcinoma of Sigmoid — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Homer L. Todd M. D.

Address 735 N. Fulton Ave. Date signed 8/23/45

VS 150

Please write clearly, with ink. Entry of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31786 / 937

Registered No. G31786

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 S. Linwood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Kataadaris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Panagiota

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 - 1880

8. AGE: Years 65 | Months 0 | Days 7 | If less than one day: hr. min.

9. Birthplace Turkey Larissa Greece (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business Own

FATHER — 12. Name Elias Katsadaris
13. Birthplace Greece

MOTHER — 14. Maiden Name ?
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/40 (month) (day) (year)
(c) Cemetery or crematory Greek Evangelismos
Location Windsor Mill Rd

18 (a) Funeral director Lelly & Leitch
(b) Address 4028 Liberty Hts.

19 (a) 23334 (Filed by registrar) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1940 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Cardiac arrest — Duration

Due to: Coronary occlusion

Due to: Hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dieffenbach
Address Johns Hopkins Hospital 8/27/40

VS 150

Caution: Write plainly, with unfading ink. Every item of information should be carefully supplied. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G31787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31787 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 60 Stansbury Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Atha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1929

8. AGE: Years 16 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Helper on Truck

11. Industry or business Continental Can Co.

FATHER
12. Name Robert Atha
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma Dunbar
15. Birthplace W. Va.

16 (a) Informant Mrs. Emma Atha
(b) Address Stansbury Rd. Dundalk

17 (a) Raymond (Burial, cremation, or removal) (b) Date thereof 8 - (month) - 45 (day) (year)

(c) Cemetery or crematory
Location Beckley, W. Va.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe Street

AUG 23 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1945, at 6:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: August 7, 1945 1-4

(a) Date of injury 5:30 P. at 5:30 P. M.

(b) Where did injury occur Lakewood ave. & Dillon St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? no.

(d) Means of injury Riding on truck was struck

23. Signature Howard D. Madeira M.D. Medical Examiner.

Date signed August 22, 1945.

VS 151

G31788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 198

Registered No. G31788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 6
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State So. Car. (b) County Florence
(c) City or town Lake City (If outside city or town limits, write RURAL and give town)
(d) Street No. Bot. 49, Route 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Luther McLaam

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Louise Harrison Mc Laam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1916

8. AGE: Years 28 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace Lake City, So. Car. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Eddie McLaam
13. Birthplace So. Carolina

MOTHER
14. Maiden Name Rose Graboy
15. Birthplace So. Carolina

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location

18 (a) Funeral director
(b) Address

19 AUG 23 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

UNIVERSITY MEDICAL SCHOOL AUG 23 1945 COMMISSIONER OF HEALTH

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1945, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945, to Aug. 17 1945, and that I last saw him alive on Aug. 17 1945.

Immediate cause of death: Dislocation of 5th cervical vertebra — Duration
Due to: Execution by hanging
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Harris M. D.
Address Medical Arts Bldg. Date signed 8-17-45

VS 150

2912

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KEB #631789 BALTIMORE CITY HEALTH DEPARTMENT G31789
Registered No.

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 1
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Walther Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha ~~Malphas~~ Virginia Malpass

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Stewart B. Malpass (USAAF) 6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) June 16, 1912

8. AGE: Years	Months	Days	If less than one day
33	2	6	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Jessie Dudley Neal (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Genevia Smith
15. Birthplace South Carolina

16 (a) Informant Baltimore City Hospts. records
(b) Address 4940 Eastern Avenue

17 (a) Burial Transit (Burial, cremation, or removal) (b) Date thereof 8-24-45 (month) (day) (year)
(c) Cemetery or crematory Oakdale
Location Wilmington, N. Carolina

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 23 1945

Physician's or Undertaker's Address Wilmington, N.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1945; at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 1945 to Aug. 22 1945 and that I last saw h. alive on Aug. 22 1945

Immediate cause of death
Lobar Pneumonia
Embolism

Duration 3 Weeks ± 3 Wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hospitals Date signed 8-23-45

T. P. Jernigan

- 2 -

Please write plainly in ink; avoid abbreviations. Physicians: please write the causes of death clearly and legibly. Information should be complete and correct age is especially important.

G31790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G31790 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline and
(c) Hospital or institution: St. Joseph's Hosp. ward
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 E. 30th. St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eugene Conway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Wh.	Wid.

6 (b) Name of husband or wife Bella -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 33? July 5 1891

8. AGE: Years	Months	Days	If less than one day
54	1?	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Park Police
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-15 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 1945 (b) [illegible] Williams (c) [illegible]
(a) Date rec'd by registrar (b) Registrar (c) File Year

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/45 19 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20/45 19 to 8/23/45 19, and that I last saw h alive on 8/23/45 19

Immediate cause of death	Duration
Due to Cardio-pyaelop accident.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Rodgers M. D.
Address St. Joseph's Hosp. Date signed 8/24/45

VS 190

G31791 G31791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G31791

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5222 Biddison Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Saverio De Cicco

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Annam De Cicco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 - 1869

8. AGE: Years	Months	Days	If less than one day
75	8	27	hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Alphonso De Cicco
13. Birthplace Italy

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Alphonse De Cicco
(b) Address 5222 Biddison Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5302 Harford Road

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945 at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 22 1945 and that I last saw h[illegible] alive on Aug 22 1945

Immediate cause of death

	Duration
Due to Pulmonary Edema Uremia	
Due to Subarachnoid Hemorrhage	8/19/45 to 8/22/45
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips
Address Madison & Linda Ave Date signed 8/28/45 M.D.

Huntington Williams, M.D.

VS 150

X

G31792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15

G31792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Woodyear Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hanson Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Chas. Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Hanson Wells
13. Birthplace Chas. Co. Md.

MOTHER
14. Maiden Name Louise Bell
15. Birthplace Chas. Co. Md.

16 (a) Informant Bettie Wells
(b) Address 822 Woodyear Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 9 Huntington Williams, Mgr. St.

19 (a) Date received by Registrar 8-27-45 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 45, 19 10:55 at A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculous Peritonitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed August 27, 1945.

G31793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

G31793

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) l. c. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Dare S 21441

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5 Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/24/45

8. AGE: Years | Months: 45 | Days: 29 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles Dare
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Frances
15. Birthplace Washington, D. C.

16 (a) Informant Charles Dare
(b) Address 807 Gilmor Street

17 (a) Burial (b) Date thereof 8/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Maryland

18 (a) Funeral director Charles A. Alexander
(b) Address 927 N. Mount St.

19 (a) [illegible] (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945, at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Edema of Lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mooreen M.D.
Medical Examiner.
Date signed August 23, 1945.

G31794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G31794 Registered No.

Permanent Provision

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Logan, W. Va
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy S. Gore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1916

8. AGE: Years	Months	Days	If less than one day
28	8	6	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Pipe Coverer

11. Industry or business Md Drydock Co

FATHER 12. Name J. J. Gore

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden Name Anna L. Driggers

MOTHER 15. Birthplace W. Va.

16 (a) Informant J. J. Gore

(b) Address Logan W. Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)

(c) Cemetery or crematory Godby Cem

Location Logan W. Va

18 (a) Funeral director Tom Cook Inc

(b) Address 127 57 Race St

19 (a) Date received AUG 28 1945 (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945 at 10 A.M 55

21. I certify that I took charge of the remains described above, held an Aut & Insp thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured 5th Cervical vertebra cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-14-45 at 6:30 P.M. 27 45

(b) Where did injury occur? Meadowbrook Pool Swimming Pool

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Dived into shallow water

23. Signature Thomas J. Mercein M.D. Medical Examiner.

Date signed 8-23-45

G31795

G31795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Pitman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eileen Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-44

8. AGE: Years	Months	Days	If less than one day
	10 mos	24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Wilson
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth Kidd
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director Wm Cox Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 23 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug. 22. 1945, at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2nd 1945, to Aug. 22 1945, and that I last saw him alive on Aug. 22 1945

Immediate cause of death Shock

Due to Diarrhea

Due to

Other Conditions Dehydration Acidosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Cornett Batson M. D.
Assistant Resident
Address Johns Hopkins Hosp. Date signed 8/23/45

G31796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 104 B

G31796
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) 9d.

2. USUAL RESIDENCE OF DECEASED: Worcester
(a) State Md (b) County Wor.
(c) City or town Stockton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Hancock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Isaac Hancock
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Feb. 23 1877

8. AGE: Years	Months	Days	If less than one day
68	5	29	hr. min.

9. Birthplace Worcester Co. - Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Wm. Taylor
13. Birthplace Stockton, Md.

MOTHER
14. Maiden Name Sarah Steward
15. Birthplace Maryland

16 (a) Informant Isaac Hancock
(b) Address Stockton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26/1945 (month) (day) (year)
(c) Cemetery or crematory Parnell
Location Stockton Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 200 E Pulaski St

19 (a) 8-28-1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945, at 3:26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1945 to 8-22 1945. and that I last saw h[illegible] alive on Aug 22 1945.

Immediate cause of death Heart failure — Duration

Due to Cerebral embolism

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation 8-22-45

Major findings of operation: Ruptured st. antrum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W B Downey M. D.
Address University Hosp. Date signed 8-22-45

Huntington Williams, M.D.

VS 150

X

G31797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G31797 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 Grantley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 + 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 748 Grantley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gustav K. Wehe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Louise Wehe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8-1871

8. AGE: Years	Months	Days	If less than one day
74	7	14	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Ret. Brakeman
11. Industry or business B & O RR.

FATHER
12. Name Joseph Wehe
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs. Alma Fiske
(b) Address 748 Grantley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo. F. Boyer Jr
(b) Address 512 Hollins St

Filed AUG 24 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1943 to Aug. 22 1945 and that I last saw him alive on Aug. 22, 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Generalized Arteriosclerosis — 1

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clement A. Kupp M.D.
Address 3030 Edmondson Ave Date signed 8/22/45

VS 150

G31798

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31798 ✓ 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edgewood & 33rd
(c) Hospital or institution: Union Memorial 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 723 East Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY HEWITT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Evelyn E. Hewitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18-1902

8. AGE: Years	Months	Days	If less than one day
43	7	4	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Service Man

11. Industry or business Dept. Store

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Evelyn E. Hewitt
(b) Address 723 E. Cold Spring Lane

17 (a) Burial (b) Date thereof Aug 25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mountcastle Cem
Location Dorsey Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St

19 (a) AUG 24 19 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/45 19 , at 8:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 8/22/45

VS 151

X

LURIE

G31799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G31799

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Lagrange 13
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Furko.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 N Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacab Lurie

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-5274

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Jacobs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April, 10, 1895

8. AGE: Years	Months	Days	If less than one day
50	4	13	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Tailor

FATHER
12. Name Nathan Lurie
13. Birthplace Russia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Sarah Lurie
(b) Address 1653 N Bentalou St

17 (a) Burial (b) Date thereof Aug, 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 Aug 24 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 23 1945 and that I last saw h[illegible] alive on Aug 23 1945.

Immediate cause of death Cardiac Insufficiency
Coronary Thrombosis
Cardiac Failure
Coronary Thrombosis
Due to myocardial infarction
Bronchopneumonia
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lewis M Baldwin M. D.
Address West Baltimore General Hospital Date signed Aug 24 1945

VS 150

X

G31800 ✓ G31500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 W. Lafayette ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norflet J. Everett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Norflet Everett

13. Birthplace Va

MOTHER 14. Maiden Name Isabella Carter

15. Birthplace Va

16 (a) Informant Mrs Anna Everett

(b) Address 1714 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)

(c) Cemetery or crematory Location Suffolk Va

18 (a) Funeral director Samuel H. Hemsley

(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) AUG 24 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1945, at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945, to 8/22 1945, and that I last saw him alive on 8/22 1945

Immediate cause of death: Cardio-Respiratory failure — Duration

Due to Administration of an anesthetic (G.O.E.)

Due to

Other Conditions Ruptured semilunar cartilage - left knee (Include pregnancy within 3 months of death)

Date of operation 8/22/45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April, 1945 at ? M
(c) Where did injury occur? ? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ? (Specify type of place) While at work? ?
(e) Means of injury

23. Signature Hollis J. Marconi, M.D. X
Address Md. Gen. Hosp. Date signed 8/22/45

Please write plainly, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or location: Baltimore, Md. 26
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 S. Lehigh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Raimondo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1934

8. AGE: Years 11 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation School-boy

11. Industry or business

FATHER 12. Name John Raimondo

FATHER 13. Birthplace Greece

MOTHER 14. Maiden Name Josephine Canimarata

MOTHER 15. Birthplace Balto. Md.

16 (a) Informant Mary Schwartz

(b) Address 312 E. Lehigh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Katy

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son

(b) Address 801 W. Fayette St.

AUG 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 19 45, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cranial Vertebrae

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 3:30 P.M. 8-22-45

(b) Where did injury occur? Mason & Eastern Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No

(d) Means of injury While riding bicycle was struck by truck.

23. Signature Thomas J. Madden M.D. Medical Examiner.

Date signed August 23, 1945.

VS 151

La Motte J. ✓

G31802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G31802 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Gen Hospital 12 → 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Johns L. La Motte

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida (nee Johnston)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1863

8. AGE: Years: 82 | Months: 2 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md (Town, county, and state)

10. Usual Occupation: Packer

11. Industry or business: Canning

FATHER
12. Name: Francis LaMotte
13. Birthplace: Balto. Co. Md

MOTHER
14. Maiden Name: Elizabeth Linton
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mrs Burrows
(b) Address: Sparks, md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1945 (Month) (day) (year)
(c) Cemetery or crematory: Black Rock
Location: Butler, Maryland

18 (a) Funeral director: Langdon M. Brooks
(b) Address: Sparks, Md

19 (a) (Date received by Registrar) AUG 24 1945 Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1945, at 10:24 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1945, to August 23 1945, and that I last saw her alive on August 23 1945.

Immediate cause of death: Cardiac Failure

Due to: Chronic hypertension Cardiovascular disease

Due to: Generalized arteriosclerosis

Other Conditions: Cerebral palsy 2 degree burns of lower extremities

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident.
(b) Date of occurrence: July 3, 1945 at 3 P. M
(c) Where did injury occur: Northern Home, Fremont (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Scalded with hot water.

23. Signature: J. M. Carroll M. D.
Address: Md Gen. Hosp. Date signed 8-24-45

Howard J. Masonis, M.D. X

VS 150

Please write plainly with pen or typewriter. Do not use pencil. Do not fold. Use only black or blue-black ink. Physicians: please write the causes of death clearly and legibly. Be sure that the information concerning the medical certification is complete, that the cause of death is correctly stated, and that the correct age is especially important.

G31803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G31803 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 6
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 2 7/8
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 2 7/8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby boy Jacobs

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~:
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/20/45

8. AGE: Years	Months	Days	If less than one day
		2	21 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Newborn infant.

11. Industry or business —

FATHER
12. Name Sydney Jacobs
13. Birthplace Md.?

MOTHER
14. Maiden Name Julia Buczkowski
15. Birthplace Md.

16 (a) Informant Mother
(b) Address

17 (a) Burial (b) Date thereof Aug 24th 1945
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Holy Rosary
Location Gorsuch Mill Road

18 (a) Funeral director Leo S. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by registrar) AUG 24 1945 (b) Huntington Williams, M.D. Address Mercy Hosp. Date signed 8-23-45

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1945 at 8 46 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1945 to 8/23 1945, and that I last saw him alive on 8/23 1945.

Immediate cause of death	Duration
Cardio-Resp. Failure	
Due to Possible Trachea-esophageal fistula	
Due to Prematurity	
Other Conditions Baby 1st twin wt. 3-13 3/4 lbs. Resp. bad from birth.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter K. Spelsberg, M.D.
Address Mercy Hosp.

X

Instructions: Please answer all questions. Use extra sheet if necessary. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

✓ G31804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Custis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 5, 1874

8. AGE: Years: 71 | Months: 1 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Essex Co. Va (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace

MOTHER 14. Maiden Name: Nana King
15. Birthplace: Essex Co. Va

16 (a) Informant: James A. Custis
(b) Address: 1514 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Mrs. Sam. H. Hall
(b) Address: 1631 Druid Hill Ave

19 (a) (b)
(Date received by registrar) Registrar

Aug 24 1945 Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22 1945 at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/45 to 8/22/1945 and that I last saw h[illegible] alive on 8/21/1945

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension Cardio	
Due to: Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W. H. Harris M. D.
Address: 601 Warren Ave Date signed: 8/23/45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31805

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Druid Hill Avenue (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Walter W. Lewis

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maude H.

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) June 1, 1889

8. AGE: Years 56 | Months 2 | Days 22 | If less than one day _____ hr. _____ min.

9. Birthplace Tappahannock, Va. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Maude H. Lewis
(b) Address 2218 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Jas. George W. Hulbert
(b) Address 1631 Druid Hill Ave

19 (a) AUG 24 19 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1945, at 1:20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to _____

Other Conditions _____
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury _____ M.
(b) Where did injury occur? _____
(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____
(d) Means of injury _____

23. Signature Howard J. Clemens M.D. Medical Examiner.
Date signed Aug 27 1945.

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G31806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G31806

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Saratoga St.
(c) Hospital or institution: Apt # 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Saratoga St. # 6 (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Albert Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Maggie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1908

8. AGE: Years 37 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Cheraw, S.C. (City, county, and state)

10. Usual Occupation Riveter

11. Industry or business

FATHER
12. Name A. M. Bowman
13. Birthplace Cheraw, S.C.

MOTHER
14. Maiden Name Jennie Pegues
15. Birthplace S.C.

16 (a) Informant Mrs. Margaret Bowman
(b) Address 907 Saratoga St. # 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George W. Hubbard
(b) Address 1631 Druid Hill Ave.

19 (a) Aug 24 1945 (Date rec'd by registrar) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/1945 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19/1945 to 8/21/1945 and that I last saw h[illegible] alive on 8/19/1945

Immediate cause of death

Due to Broncho-pneumonia
Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopay:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1300 N. Fremont Ave. Date signed 8/23/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G31807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison - Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. Preston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Manley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Halifax N.C.
(town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name George Manley
13. Birthplace Halifax N.C.

MOTHER
14. Maiden Name Minnie Long
15. Birthplace Halifax, N.C.

16 (a) Informant Mary Manley
(b) Address 135 N. Preston St.

17 (a) Burial (b) Date thereof Aug. 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Halifax, N.C.
Location

18 (a) Funeral director Mrs. Cuny W. Hilliard
(b) Address 1631 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

AUG 24 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1945 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1945 to 8/21 1945 and that I last saw him alive on 8/21 1945

Immediate cause of death	Duration
Terminal Pneumonia	2 days
Due to Cerebral Hemorrhage	5 days
Due to Hypertension - Uremia C. V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobe M. D.

Address Md. Genl. Hospital Date signed 8/24/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G31808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1306 ½ McCulloh ST
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 ½ Mc Culloh St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ida Zander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1884

8. AGE: Years 61 Months 4 Days 14 If less than one day hr. min.

9. Birthplace Stony Creek, Va (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name George Dillard
13. Birthplace Stony Creek Va

MOTHER
14. Maiden Name Minerva Parham
15. Birthplace Stony Creek, Va

16 (a) Informant Addie Taylor
(b) Address 1306½ Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Stony Creek, Va

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) AUG 24 1945 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945, at 7:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1945 to Aug 22 1945 and that I last saw h[illegible] alive on Aug 22 1945

Immediate cause of death	Duration
Arteriosclerosis (Generalized)	
Due to	
Due to	
Other Conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Banfield M. D.
Address 804 N. Carey St Date signed 8/22/45

Correct age is especially important. Physicians: please write out cause of death clearly and legibly.

VS 3

G31809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31809

Registered No. 1310

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4812 Pennington ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4812 Pennington ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Catherine E Steinbcomb.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jefferson D. Steinbcomb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1870

8. AGE: Years 74 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name John Schramm

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know

MOTHER 15. Birthplace Germany

16 (a) Informant George Steinbcomb

(b) Address 3502 Seventh St Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Md

18 (a) Funeral director A. Howard Evans

(b) Address 1400 St Paul St

19 (a) AUG 24 1945 (Date rec'd by Registrar) (b) Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945, at 4209 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Aug 24 1945, and that I last saw her alive on Aug 20 1945.

Immediate cause of death: Uterine Sclerotic Cystic Vascular Renal Disease

Due to: Cardiac Decompensation

Due to: Senile Debility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Lloyd Lukens M.D.

Address 320 Cathedral Date signed 8/24/45

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G31810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31810 Registered No. 131 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 James Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 James Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hilda Marie Germershausen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Henry Germershausen
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14-1892

8. AGE: Years	Months	Days	If less than one day
53	6	8	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Timothy F. Riordon
13. Birthplace Md

MOTHER 14. Maiden Name Amelia Roerentrop
15. Birthplace Md.

16 (a) Informant Mr. Henry Germershausen
(b) Address 1210 James Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) [illegible] (b) [illegible] (Date rec'd by Registrar) Registrar Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1945, at 5:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1945 to 8/22 1945, and that I last saw h[illegible] alive on 8/22 1945

Immediate cause of death	Duration
Arteria sclerotic Cardiac Vascular disease	2 yrs
Due to	
Due to	
Other Conditions Chronic Nephritis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 1030 W Wilkens Date signed 8/23/45

ave X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G31811 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry, item of information should be entered if correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 N. 42nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write Rural, and give town)
(d) Street No. 1208 N. 42nd Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Noah C. Sellers

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-10-1480

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah A. Sellers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13-1884

8. AGE: Years 61 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Paint Filler

11. Industry or business Davis Paint Products Co.

FATHER
12. Name Noah Sellers
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda —
15. Birthplace Maryland

16 (a) Informant Mrs. Sarah A. Sellers
(b) Address 1208 N. 42nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date received) AUG 24 1945 (b) (Registrar) Huntington Williams Reg.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22- 1945 at 9-22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Aug 22 1945 and that I last saw h— alive on Aug 22 1945

Immediate cause of death: Cardiac decompensation — Duration 7 yrs.

Due to: Cardio-vascular disease — 3 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Noah C. Sellers M.D.
Address 846 W 36th St. Date signed 8/23/45.

X

G31812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. G31812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Parkside Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD THOMAS CUNNINGHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Spanish American	none	M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired foreman
11. Industry or business City of Baltimore

FATHER
12. Name Edward T. Cunningham
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Carback
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Rose Deems
(b) Address 4017 Parkside Drive

17 (a) Burial (b) Date thereof 8/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
AUG 24 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to Aug 21 1945, and that I last saw h[illegible] alive on Aug 20 19 45.

Immediate cause of death Cardiac failure — Duration 5 min.
Due to Hypertensive Card. Vas. Renal disease.
Due to Senility
Other Conditions Senile Prostatic Hypertrophy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William G. Mitchell M.D.
Address 20 W. Madison Date signed 8/23/45

VS 130

PLEASE WRITE PLAINLY, with pen and ink. Entries must be made in all spaces. If any space does not apply, write "None" or "Not Applicable." Use no abbreviations or ditto marks. Be sure and answer each question. Physicians: please write the causes of death clearly and legibly. Please state the disease causing death, or in deaths from violence, state the means of injury. State whether accidental, suicidal or homicidal. Please write the causes of death clearly and legibly

G31813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G31813 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Wyanoke Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Wyanoke Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Mallalieu

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Sarah Eliz. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	--	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Edward Mallalieu
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Eliz. Sneed
15. Birthplace Md.

16 (a) Informant Mrs. Sarah E. Mallalieu
(b) Address 608 Wyanoke Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy.
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 1945, and that I last saw him alive on 1945

Immediate cause of death Carcinoma of brain (metastatic) — Duration

Due to Bronchogenic Carcinoma of Lung

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 8-27-45

X

I hereby certify that I attended the deceased from the date and to the date stated above, and that I last saw h alive on the date stated above. Physicians: please write the causes of death clearly and legibly. Be correct. age is especially important.

G31814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G31814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Sarah Dodson

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Walter R. Dodson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/82

8. AGE: Years	Months	Days	If less than one day
53	4	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Albert Ghent
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Minnie Brumwell
15. Birthplace Md.

16 (a) Informant Mr. Walter R. Dodson
(b) Address 401 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) AUG 24 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/45 19 45, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1943 to 8/22 1945.
and that I last saw her alive on 8/21 19 45.

Immediate cause of death: Carcinoma of breast metastases to brain pelvic bones.
Duration: 8 years

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Wallenstein M. D.
Address 148 W 36th St Date signed 8/23/45

VS 150

X

Certificate must be filled out, signed and returned to Bureau of Vital Statistics, Room 100, City Hall, within 24 hours after death. Physicians: please write the causes of death clearly and legibly. Information should be complete and correct as far as possible. Accuracy in statement of cause of death is especially important.

G31815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31815 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Vito

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Vito
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1877
8. AGE: Years 68 | Months 2 | Days 18 | If less than one day: hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Tony J.
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Catherine Schaefer
(b) Address 3514 Gough St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Wendell Stoppel
(b) Address 312 S. Highland Ave
19 Aug 24 1945 Filed by me Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1945, at 4 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1945 to 8-21 1945 and that I last saw her alive on 8-21 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. S. Robertson M. D.
Address St. Josephs Hosp Date signed 8-21-45

VS 180

Except age is especially important. Physicians: please write the causes of death clearly and legibly.

G31816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G31816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2837 - Booket Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 - Booket Ave.
(If rural give R.F.D. or Star Route No.)
(e) Citizen of foreign country? No. If yes, name country. Cherry Hill Md

3 (a) FULL NAME Kelly Dail

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Leona Dail

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1866

8. AGE: Years 79 | Months 1 | Days 5 | If less than one day Hr. min.

9. Birthplace Hertford N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name James Dail
13. Birthplace Hertford, N.C.

MOTHER
14. Maiden Name Mary
15. Birthplace Hertford N.C.

16 (a) Informant Ida M. Dail
(b) Address 2837 - Booket Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemt.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 - Hilmead Hill Ave.

19 (a) Filed AUG 24 1945 Registrar Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1945 at 5:P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945 to Aug 21 1945 and that I last saw him alive on 8/21/1945

Immediate cause of death: Arter Sclerotes

Due to Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reuold Blighton M. D.
Address 501 Cherry Hill Rd Date signed 8/22/45
Blighton X

VS 150

REGISTRAR'S NOTICE: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G31817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 939 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Shelton Walker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1921.

8. AGE: Years	Months	Days	If less than one day
24	6	19	hr. min.

9. Birthplace Nottaway, Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Shelton
13. Birthplace

MOTHER
14. Maiden Name Alease Edwards
15. Birthplace Nottaway Va.

16 (a) Informant Robert Shelton
(b) Address 939 W. Mulberry St.

17 (a) Shipped. (Burial, cremation, or removal) (b) Date thereof Aug 24 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Blackstone, Virginia.

18 (a) Funeral director Mrs. Katie R. Williams.
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945 at 11:20 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wounds brain and abdomen

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-22-45 at 12:15 P. M.
(b) Where did injury occur? Saratoga & Poppleton Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Shot during altercation.

23. Signature Howard F. McGrain M.D. Medical Examiner.
Date signed August 23, 1945.

G31818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31818 Registered No. 1190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired into, that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 W. Saratoga
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Sing.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, '45

8. AGE: Years — | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dolphus Kirby
13. Birthplace Lynchburg S.C.

MOTHER
14. Maiden Name Rosa Mae Thompson
15. Birthplace S.C.

16 (a) Informant Dolphus Kirby
(b) Address 629 W. Saratoga St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug. 31st '45 (month) (day) (year)

(c) Cemetery or crematory
Location Lynchburg S.C.

18 (a) Funeral director Mrs. Katie F. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar

AUG 24 1945

VS 150

Funeral Director Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 45 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Aug 22 1945 and that I last saw h[illegible] alive on Aug 22 19 45

Immediate cause of death	Duration
Respiratory Failure	
Due to Acidosis, gastric dilatation	
Due to Diarrhea Parenteral	
Other Conditions OTITIS Media	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. D. Robinson M. D.
Address Univ. Hosp. Date signed 8-23-45

G31819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G31819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 17 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Little Pine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie E. Blake Carroll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1897

8. AGE: Years	Months	Days	If less than one day
48	5	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Abraham Carroll
13. Birthplace Eastern Shore, Md.

MOTHER 14. Maiden Name Eliza Simpson
15. Birthplace Eastern Shore Md.

16 (a) Informant Jos. Carroll (brother)
(b) Address 122 Ridgely St.

17 (a) Burial (b) Date thereof Aug 24 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie F. Willis
(b) Address 322 N. Schroeder St.

19 (a) AUG 24 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20th 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Bruised bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-20-45 at 3 A. M.
(b) Where did injury occur? Mt. Carroll Park.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury struck by auto.

23. Signature Howard J. Adkerson M.D.
Medical Examiner.
Date signed 8-21-45

VS 151

G33[illegible]20 Young ✓ 631820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Hampton Young

3 (b) If veteran, name war World War I

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Berry Mason Colston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-70

8. AGE: Years 74 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Surgeon

11. Industry or business

FATHER
12. Name William Young
13. Birthplace Virginia

MOTHER
14. Maiden Name Frances Kempen
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) AUG 24 1945 (Date rec'd by registrar) Washington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1945 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1945 to 8-23 1945; and that I last saw h[illegible] alive on 8-23 1945

Immediate cause of death: Coronary Occlusion — Duration

Due to: Arteriosclerotic Heart Disease — Duration 3 10 yrs

Due to:

Other Conditions: Cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Orchard

Address 720 Hop[illegible] Hosp Date signed 8/23

VS 150

Please write plainly, with undertaking ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31821 ✓ 1310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Pimlico Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Ely.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lillie R.
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18 1864

8. AGE: Years 80 | Months 10 | Days 4 | If less than one day hrs. min.

9. Birthplace Balto. Md. (town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name James Ely
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name M. Settles
15. Birthplace Balto. Md.

16 (a) Informant Paul W. Conner
(b) Address 3815 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Lawn
Location E. North Ave

18 (a) Funeral director John A. Hudson.
(b) Address 3000 E. Eager St.

19 AUG 24 1945 (Registrar's signature) Huntingtown Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22nd 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 44 to Aug 22 19 45 and that I last saw h alive on Aug 22 19 45

Immediate cause of death — Duration

Due to Chronic Myocarditis with

Due to Contributory Cerebral Sclerosis

Other conditions Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature L. A. Richardson
Address 1120 W. 25th St. Date signed Aug. 24, 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry items of information should be entered in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G31822

CWK-81603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 2- 24
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.	6 (b) Name of husband or wife	6 (c) If alive, give age
Male	White	Single		years

7. Birth date of deceased (mo., day, yr.) Jan. 30-1870

8. AGE: Years	Months	Days	If less than one day
75	6	14	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name Alex. Anderson
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Brimmer
15. Birthplace Scotland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1943, to Aug. 14 1945 and that I last saw him alive on Aug. 14 1945.

Immediate cause of death: Coronary Thrombosis — Duration: about 11 min.
Due to: Arteriosclerotic cardio vascular disease
Due to:
Other Conditions: Arteriosclerotic gangrene of foot
(Include pregnancy within 3 months of death)
Date of operation 5-26-45
Major findings of operation: as above
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Grant M. D.
Address Balto City Hospitals Date signed 8-22-45

VS 150

2914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31823 JL - 15836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 ✓ Registered No. G31823

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 9 - 17 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Thames St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20? 1866 ?

8. AGE: Years	Months	Days	If less than one day
79 ?	4 ?	27 ?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Charles Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Taylor
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 24 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Aug. 17 1945 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30, 1929 to Aug. 17 1945, and that I last saw him alive on Aug. 17 1945.

Immediate cause of death ? Hypostatic pneumonia — Duration 2 days

Due to Generalized arterio-sclerosis. — 14 yrs

Due to

Other Conditions Senile dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Dowell M. D.
Address Balto City Hospitals Date signed 8-22-45

VS 150

2913

X

G31824 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G31824
Registered No.

CERTIFICATE OF DEATH 1226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d
(e) Length of stay in Baltimore (yrs., mos., or days) 14d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Acton Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph Wise Krebs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Helen Mae Krebs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	5	hr. min.

9. Birthplace Mississippi (Town, county, and state)
10. Usual Occupation Accountant Dept., Glen Martin
11. Industry or business

FATHER
12. Name Mr. Hubert Krebs
13. Birthplace Mississippi

MOTHER
14. Maiden Name Lucretia Batiste
15. Birthplace Mississippi

16 (a) Informant Mrs Helen Krebs
(b) Address 3017 Acton Rd-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location

18 (a) Funeral director Wendell E Humphreys
(b) Address 6067 Harford Rd. Huntington Williams, Md.

19 (a) Date received by registrar 8 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1945 at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1945 to Aug. 21 1945 and that I last saw him alive on Aug. 21 1945

Immediate cause of death	Duration
intestinal obstruction	
Due to ? mesenteric thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: intestinal obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Lippitt M. D.
Address Union Memorial Hosp Date signed 8-24-45

VS 150

Use white ribbon, with one addition ink. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G31825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G31825

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4319 Springwood Ave.
(c) Hospital or institution:

2667

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 Springwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA MAGDALENA ORTH

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Henry Orth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1857

8. AGE: Years 87 | Months 9 | Days 23 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frederick Kramer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ann Kuszmaul
15. Birthplace Pa.

16 (a) Informant Mr. Harry Miller
(b) Address 401 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 24 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug. 24, 1945, at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/11 1944 to 8/24 1945, and that I last saw h[illegible] alive on 8/23 1945

Immediate cause of death: Cancer of left Breast — Duration: 2 Years

Due to

Due to

Other Conditions Senility —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Box Belair Md. Date signed 8/24/45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data not applicable should be so stated. Physicians: please write the causes of death clearly and legibly. Information is especially important.

G31826

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 133 B

G31826 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Linthicum Hgts. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Maple Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Selby Rider

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-12-5973

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Bessie C. Rider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	11	hr. min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Hopeman Bros.

FATHER
12. Name: Edmund A. Rider
13. Birthplace: A. A. Co.

MOTHER
14. Maiden Name: Rebecca Harman
15. Birthplace: A. A. Co.,

16 (a) Informant: Mrs. Bessie C. Rider
(b) Address: 100 Homewood Rd., Linthicum Hgts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge Cem.
Location: Washington Boulevard & Dorsey Rd.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) [illegible] (b) [illegible]
Date received: AUG 24 1945 Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1945; at 2:15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1945; to 8/23 1945; and that I last saw him alive on 8/23 1945.

Immediate cause of death	Duration
Terminal Pneumonia	1 day
Due to Septicemia	3 days
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Martin E. Strobel M. D.
Address: Md. Gen'l. Hospital Date signed 8/23/45

Please write plainly, with indelible pencil. Any omission or incorrect information should be carefully supplied, but age is especially important. Physicians: please write the causes of death clearly and legibly.

G31827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G31827

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Sanford Pl.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name of town)
(d) Street No. 525 Sanford Place
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia E. Bright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Widow

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Edenington N. C.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At home

FATHER
12. Name John Black
13. Birthplace N. C.

MOTHER
14. Maiden Name Ellis?
15. Birthplace N. C.

16 (a) Informant Clifton Taylor
(b) Address 525 Sanford Place

17 (a) Burial (b) Date thereof 8-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Co.

18 (a) Funeral director Samuel W. Edmondson
(b) Address 628 N. Gilmor St.

19 (a) Huntington Williams
(Date rec'd by registrar)

AUG 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 - 1945, at 3:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
Cerebro Vas. Dis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L. Shuba M.D.
Medical Examiner.
Date signed 8-22-45

HEP #1940 931828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G31828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 1 1M-1D
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore n St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Allen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Huey Kellom

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. ?, 1894

8. AGE: Years	Months	Days	If less than one day
50	8	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lloyd Henry (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Willie Anna Kellom (D)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 24 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Melfa, Virginia

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) AUG 24 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945, at 4:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22, 1945 to Aug. 23 1945, and that I last saw him alive on Aug. 23, 1945

Immediate cause of death Uremia
Carcinoma urinary bladder — Duration about 6 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8-4-45

Major findings of operation:
as above

of autopsy: Papillary carcinoma of bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Orrell M. D.
Address Balto City Hosps Date signed 8-23-45

VS 150

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

G31829

478129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B2

Registered No. G31829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Victor

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 215-03-1957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Irene.

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 12-31-92

8. AGE: Years	Months	Days	If less than one day
52	7	6	hr. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual Occupation: Salesman.

11. Industry or business

FATHER
12. Name: Julius Victor
13. Birthplace: Russia

MOTHER
14. Maiden Name: Anna.
15. Birthplace: Russia

16 (a) Informant: Relative.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Old Frederick Rd

18 (a) Funeral director: Thos. F. Kenny
(b) Address: Hollins & Gilmor St

19 AUG 25 1945 (Date received by local reg.) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1945 at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to Aug. 22 1945, and that I last saw him alive on Aug. 22 1945

Immediate cause of death: Bronchopneumonia

Due to: Carcinomatosis

Due to: Carcinoma of stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: Aug. 1, 1945

Major findings of operation:

of autopsy: Not reported yet

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Richard [illegible] Kiefer X
Address: [illegible] Date signed: Aug 25 1945

VS 150

PRESS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31830

50 #94755

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Embers or Carrie Enders

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
60 or 65?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Kleek
13. Birthplace Virginia

MOTHER
14. Maiden Name Louise ?
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25/45 (month) (day) (year)
(c) Cemetery or crematory Thanksgiving
Location Staunton Va

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 AUG 25 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14, 1945 to Aug. 22, 1945, and that I last saw h ER alive on Aug. 21, 1945.

	Duration
Immediate cause of death Cerebro vascular accident -	?
Due to Hypertension + Generalized arteriosclerosis	?
Due to	
Other Conditions Varicose ulcer of leg	

(Include pregnancy within 3 months of death)

Date of operation 8-8-45
Major findings of operation: Varicose ulcer - Skin graft
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E J Perry MD
Address Balt City Hospls Date signed 8-24-45

M. D.

VS 150

X

G31831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9

G31831
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 656 Carrahan St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Carolyn Sample

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	col.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 29, 1945

8. AGE: Years	Months	Days	If less than one day
0	1	4	— hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name George Elliott
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Virginia Sample
15. Birthplace Virginia

16 (a) Informant Virginia Sample
(b) Address 656 Carrahan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore Md
18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania ave
19 AUG 25 1945 (Date rec'd by Reg.) (b) Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1945, at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945 to 8/24 1945 and that I last saw her alive on 8/24 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Pertussis	4+wk.
Due to H. Pertussis	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mrs. E. Freeman, M. D.
Address Sydenham Hosp. Date signed 8/24/45

VS 3

Notice: Age is supposedly important. Physicians, please write the causes of death clearly and legibly.

G31832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G31832 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 W. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 W. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dovie Wells Watts

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-8-1897

8. AGE: Years 47 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Tennessee (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name David Coates
13. Birthplace Penn

MOTHER
14. Maiden Name Annie Brown
15. Birthplace Penn

16 (a) Informant Isaac Coates
(b) Address 603 W. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Nat'l Cem
Location Baltimore Md

18 (a) Funeral director William J. Jackson
(b) Address 916 Pennsylvania ave

Date received AUG 25 1945 (Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to Aug 23 1945 and that I last saw h— alive on Aug 23 1945

Immediate cause of death Gastric Carcinoma — Duration 1 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. Watts, M.D.
Address 515 Eden St Date signed 8/24/45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

631833 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 1005 - Linden Ave. (3rd Fl.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 - Linden Ave. (If rural give location) 3rd Flr
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Fleet.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Fleet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1909

8. AGE: Years 35 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Fisher

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Florence Ballard

15. Birthplace Balto. Md.

16 (a) Informant James Fleet

(b) Address 1005 - Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Lebanon

Location

18 (a) Funeral director A. Halstead

(b) Address 918 - Lewis Hill Ave.

19 (a) (Date received by registrar) AUG 25 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1945 to Aug 23 1945. and that I last saw h[illegible] alive on Aug 23 19 45.

Immediate cause of death Cerebral Hemorrhage (Duration) 3 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed Aug 27 45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631834

631834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N Broadway

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 325 Hawthorne Rd

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Dr John King Brown Eugene Seegar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Elizabeth B. Seegar

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 2-14-70

8. AGE: Years 75 | Months 6 | Days 10 | If less than one day hr. – min.

9. Birthplace Md. (Centreville)

(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER 12. Name James M Seegar

13. Birthplace Md.

MOTHER 14. Maiden Name Frances Emery

15. Birthplace Md

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville

18 (a) Funeral director Sherwood Memorial Co.

(b) Address 1080 Park Ave.

19 (a) (Date rec'd by registrar) AUG 25 1945 (b) Huntington, Maryland

VS 1500

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1945, at 900 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1945 to Aug 24 1945 and that I last saw her alive on Aug 24 1945

	Duration
Immediate cause of death Pneumonia	1 day
Cerebral Thrombosis, Collapse	
Due to Carcinoma of Stomach	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation August 21, 1945

Major findings of operation: Carcinoma of Stomach & Peritoneal implant

Autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Howard A. Kelly M.D.

Address Johns Hopkins Hosp. Date signed 8/24

G31835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore – 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Frank Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1872

8. AGE: Years	Months	Days	If less than one day
72	8	28	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christian Gross
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Bayer
15. Birthplace Germany

16 (a) Informant Mr Christian J Miller
(b) Address 1922 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3700 old Frederick Rd

18 (a) Funeral director Harry H Witzke
(b) Address 4101 E Lombard ave.

19 (a) (Date received by registrar) AUG 29 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1945, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1945 to 8/27 1945, and that I last saw her alive on 8/27 1945

Immediate cause of death	Duration
Resp failure	
Due to Bulbar paralysis + debility	1 mo.
Due to C-V accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Milton Linthicum M. D.
Address Mercy Hosp. Date signed 8/28/45

VS 150

X

G31836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56B

Registered No. G31836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilldale & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2348 Hilldale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Langenfelder (LANGENFELDER)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Henry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 3, 1899
8. AGE: Years 46 Months 4 Days 21 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Kaiser
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Kerbo
15. Birthplace Md.

16 (a) Informant Mr Henry Langenfelder
(b) Address 2348 Hilldale Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.
18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave
19 (a) (Signature of local registrar) (b) Registrar

AUG 25 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1945 at 1:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1945 to Aug. 24 1945 and that I last saw her alive on Aug. 24 1945.

	Duration
Immediate cause of death Pulmonary Embolism	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/10 1945
Major findings of operation: Adenoma
Pulmonary embolism
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Huntington Williams, M.D.
Address St. Agnes Hosp. Date signed 8/25/45

Huntington Williams, M.D.

X

G31837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G31837 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Chesley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Chesley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank M. Bootman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-16-1548

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Bootman 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1866

8. AGE: Years	Months	Days	If less than one day
78	11	9	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Manager lumber Co.
11. Industry or business

FATHER
12. Name Sherwood Bootman
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Eliz. Mace
15. Birthplace Balto. Md.

16 (a) Informant Mrs. F.M. Bootman
(b) Address 3402 Chesley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 27 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lazenby Funeral Home
(b) Address 7401 Belair Rd.

AUG 25 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24-45 19 45 at 12 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 19 45 to 8/24 19 45 and that I last saw h[illegible] alive on 8/19/19 45.

Immediate cause of death	Duration
Cancer of urinary Bladder	6 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Biopsy
Major findings of operation: Cancer of urinary bladder
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M Bootman
Address 3402 Belair Rd Date signed M 8/24/45 D.

X

JL 6[illegible]838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31838
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto. City Hospitals 4940 Eastern Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Huether

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Katherine (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	12	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Huether
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Smith
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto Md

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eleanor St

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams M.D. Registrar

AUG 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1945 to Aug. 21 1945 and that I last saw him alive on Aug. 21 1945.

Immediate cause of death	Duration
Arteriosclerotic gangrene both feet	about 6 mos.
Due to Generalized arteriosclerosis	1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6-4-45 7-6-45
Major findings of operation: as above
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Mell M. D.
Address Balto City Hospitals Date signed 8-22-45

X

G31839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G31839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N.Pat.Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N.Pat.Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna T.Brannan

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Michael Brannan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	26	hr. 27 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name August Degele
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Theresa --
15. Birthplace Balto. Md.

16 (a) Informant Micheal Brannan
(b) Address 814 N.Pat.Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redemeer Cem.
Location Balto. Md.

18 (a) Funeral director Philip Keurig Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 25 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23rd./45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Aug 23 1945, and that I last saw h[illegible] alive on Aug 23 1945.

Immediate cause of death	Duration
Coronary occlusion	1 day
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis Fisher M. D.
Address 823 N. Mast St. Date signed 8/25/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G31840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 227 S.Eaton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 S.Eaton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H.Baier

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Geo.M.Baier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr.21,1882

8. AGE: Years	Months	Days	If less than one day
63 66	3 4	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis Rau
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kolbus
15. Birthplace Germany

16 (a) Informant Mr. Geo. M. Baier
(b) Address 227 S.Eaton St.

17 (a) Burial (b) Date thereof Aug. 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23-45 19 to 8-24-45 19, and that I last saw h alive on 8-24-45 19.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	
Due to	
Other Conditions Arteriosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Gantz M.D.
Address 234 N. Caroline Date signed 8-24-45

VS 150

Huntington Williams M.D.

X

31841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31841

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Spencer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1945

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alexander Spencer
13. Birthplace Virginia

MOTHER
14. Maiden Name Helen Thompson
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address J.H.H.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 25 1945 (b) H. Huntington Williams, M.D. (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 19 45 at 12:51 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1945 to August 17 45 and that I last saw h. or alive on August 17 45.

Immediate cause of death	Duration
Acute Nutritional Disturbance	
? septicemia. Diarrhea	
Due to	
prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh
Address Date signed 8/18/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

2918

G31842 95498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Hillen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Newbill

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1926

8. AGE: Years	Months	Days	If less than one day
19	2	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edgar
13. Birthplace Va.

MOTHER
14. Maiden Name Artie Jackson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Belmont Magaha & Hughes
(b) Address 762 Pisquata St

AUG 25 1945 (Registrar's signature) (b) Huntington, West Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17, 1945 to Aug 21 1945, and that I last saw h im alive on Aug. 21 1945.

	Duration
Immediate cause of death: Cachexia	7
Due to: Tuberculous Peritonitis / Tuberculous Adenitis	1 / ?
Due to: Pulmonary Tuberculosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: none
of autopsy: Tbc of peritoneum, lung, [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. P. Jenings
Address Baltimore City Hosp Date signed 8-24-45 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully sought and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31843
L - 52437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31843

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Derry La Sane or Derry Lesane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1917

8. AGE: Years	Months	Days	If less than one day
28	5	15	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Johnson La Sane
13. Birthplace S. C.

MOTHER
14. Maiden Name Alice Williams
15. Birthplace S. C.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 25 45 (month) (day) (year)
(c) Cemetery or crematory
Location Sumter, S. C.

18 (a) Funeral director Mrs. Kenneth R. Williams.
(b) Address 322 N. Schroeder St.

19 (a) AUG 25 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1945 at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1945 to Aug. 22 1945 and that I last saw him alive on Aug. 22 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Gaeland Jr. M.D.
Address Balto. City Hosp. Date signed 8/28/45

X

G31844

HEP #90597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31844

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 9- & 27
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Sarah Ann (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Powell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1908

8. AGE: Years	Months	Days	If less than one day
36	10	25	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Finney
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Major
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 25 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Fairlawn Va.

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.
AUG 25 1945 Huntington West Virginia
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945 1945, at 4:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26, 1945 to Aug. 23, 1945, and that I last saw her alive on Aug. 23, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 8/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

M. D. B. [illegible]

G31845

HEALTH DEPARTMENT—CITY OF BALTIMORE

G31845

CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4705 Althea Ave St., ... Ward)

Length of residence in city or town where death occurred life mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME ~~Elizabeth M. Lang~~ (MARY-ELIZABETH-LANG)

(a) Residence: No. 334 STINSON St. 20-4 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	White	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, year) FEB. 12 1872

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	6	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housework

10. Date deceased last worked at this occupation (month and year) Forever

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) (State or country) BALTIMORE MD

FATHER

13. NAME John Eberhard LANG.

14. BIRTHPLACE (city or town) (State or country) DARMSTADT GERMANY

MOTHER

15. MAIDEN NAME KATHERINE KRAMER

16. BIRTHPLACE (city or town) (State or country) BALTIMORE MD

17. INFORMANT Family

(Address) 4705 Althea Ave

18. BURIAL, CREMATION, OR REMOVAL

Place LOUDON-PARK Date AUG-25 19 45

19. UNDERTAKER F. O. Wippert-Son

(Address) 1300 Eutaw Place Huntington Hotel Towers, Md

FILED AUG 25 1945 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) AUG. 22, 1945

22. I HEREBY CERTIFY, That I attended deceased from August 13, 1945 to August 22, 1945

I last saw her alive on Aug. 22, 1945. Death is said to have occurred on the date stated above, at 7.01 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Aug 22 —
Hypertension	?

Other contributory causes of importance:

Arteriosclerosis	?
Senility	—

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Fred E Kadan M. D.

(Address) 1220 Sheldon Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

v. 8. 3

G31846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G31846 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0. 0. a.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 447 Patterson Place (If rural give location)
(e) Citizen of foreign country? Patterson Place (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Padden

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11-18 [illegible]

8. AGE: Years	Months	Days	If less than one day
67 [illegible]	4	-13	hr. min.

9. Birthplace St. Paul Minn. (Town, county, and state)
10. Usual Occupation Scale Inspector
11. Industry or business

FATHER
12. Name Thomas Padden
13. Birthplace Ireland

MOTHER
14. Maiden Name Nellie Booth
15. Birthplace Unknown

16 (a) Informant Edward O. Padden (Son)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory [illegible]ville, Va.
Location

18 (a) Funeral director Mary M. Niedefeld
(b) Address 501 East 22nd Street

19 (a) [illegible] (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1945, at 11 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Edema of the Brain.

Due to

Other Conditions Generalized arteriosclerosis. Chronic Nephritis, Fatty Liver.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed August 24, 1945

G31847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Leiden & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Richmond
(c) City or town Warsaw
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Northern

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace Emporium, Richmond Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Edward
13. Birthplace Richmond Co. Va.

MOTHER
14. Maiden Name Lelia Jenkins
15. Birthplace Va.

16 (a) Informant Miss Hurt
(b) Address Md. Gen. Hosp.

17 (a) Burial (b) Date thereof 8-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Warsaw M.E. Ch.
Location Warsaw Va.

18 (a) Funeral director J. D. Mackie
(b) Address Warsaw Va.
Huntington Williams, Mgr

19 (a) 26 1945 (b) Registrar
(Filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1945, at 4:26 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to Aug 25 1945 and that I last saw h[illegible] alive on Aug 25 1945

Immediate cause of death — Duration

Massive Cerebral Hemorrhage — 1 day
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips M. D.
Address Md. General Hosp. Date signed 8/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 150

G31848 ✓ G31848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 E Baltimore St
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Stern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Stern
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs Mollie Friedman
(b) Address 1525 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W. North Ave

1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 1.30

20. DATE OF DEATH August 24 1945, at 2. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1945, to 8-24 1945, and that I last saw h[illegible] alive on 8-23 1945.

Immediate cause of death Cerebral hemorrhage.

Duration

Due to

Due to

Other Conditions Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Siegel M. D.
Address 1634 E. Baltimore St Date signed 8-25-45

VS 150

G31849 Can 5400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127B

G31849 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Hollen Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna B. Shaw

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	NONE	F	W	Widow

6 (b) Name of husband or wife Mr. — Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1885

8. AGE: Years	Months	Days	If less than one day
60	1	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business Roland Park Jr. High School

FATHER
12. Name William M. Brooks
13. Birthplace Canada

MOTHER
14. Maiden Name Susan K. Colt Maryland
15. Birthplace Baltimore, Canada

16 (a) Informant Mrs. Ada B. Gray
(b) Address 615 Hollen Rd., Balto., Md. 8/28/45

17 Final (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore, Md.
18 (a) Funeral director Milton Low Dye
(b) Address 1244 E. Pratt St.
19 (a) (Name of hospital or institution) (b) Washington, D. C.
(If not filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1945 at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 8/25 1945, and that I last saw her alive on 8/24 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Rupture of gall bladder into duodenum.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/18/45
Major findings of operation: Ruptured gall-bladder & rupture into duodenum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hedrick M. D.
Address Mercy Hospital Date signed 8/25/45

8/26 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G31850 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Penrose ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Donovan

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): about 1887

8. AGE: Years: about 58 | Months | Days | If less than one day: hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Johnson
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant: Mrs Flanagan
(b) Address 1814 Penrose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)
(c) Cemetery or crematory: St Patricks
Location: Baltimore Md

18 (a) Funeral director: Mahoney & Son Inc
(b) Address 1217 E Pratt St

19 (a) 8-26-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1945, at 12 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1945, to 8-25 1945, and that I last saw her alive on 8-25 1945.

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Hypertensive CVD	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hosp Date signed 8-26-45

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G31851 ✓ G31851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ~~D.O.A.~~ ?

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4049 EASTERN AVE. (If rural, give location) (Balto City Hosp.)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Fred'k Dorr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2 2 1880

8. AGE: Years	Months	Days	If less than one day
65	2	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Orderly

11. Industry or business City Hospital

FATHER
12. Name William F. Dorr
13. Birthplace Germany

MOTHER
14. Maiden Name Louise (Unknown)
15. Birthplace Germany

16 (a) Informant Garfield James
(b) Address 18 d/ Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location " Md.

18 (a) Funeral director William Cox Inc.
(b) Address 1217 St. Paul St.

19 (a) 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1945, at 11 5m P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture Skull

Due to

Other Conditions Multiple fractures, bruises & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-45 at 26/5 11 45 P.M.
(b) Where did injury occur? Eastern Ave. 30' west of Argyle Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature [illegible] M.D. Medical Examiner.
Date signed 8-25-45

X

G31852 [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133 [redacted] Registered No. G31852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Hickory Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] Pauline E. Hedrick
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife deceased - Mr. Eugene Hedrick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George W. McKnew
13. Birthplace Virginia

MOTHER
14. Maiden Name Johanna Hoffman
15. Birthplace Baltimore, Md.

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Friedland, Baltimore Co. Md.

18 (a) Funeral director Quirgel Funeral Home
(b) Address 3631 Falls Road

19 (a) Aug 26 1945 (Date received by registrar) (b) Huntington Willia[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1945 at 2.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1945 to Aug 24 1945 and that I last saw h[illegible] alive on Aug. 24 1945

Immediate cause of death	Duration
resp. failure	
Due to uremia + acidosis	
Due to hydronephrosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Naugatuck Jr. M. D.
Address 732 E. University Pkwy. Date signed 8/24/45

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G31853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G31853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1444 Light St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1444 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Cushnew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Morris Cushnew
13. Birthplace Russia

MOTHER
14. Maiden Name Nagie
15. Birthplace Russia

16 (a) Informant Philip Cushnew
(b) Address 1444 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem' Location West. Blvd

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E Baltimore St

28 1945 (Date filed by registrar) Thurlington Hollingsworth

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-45 19 , at 7 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 45 to Aug 26 19 45, and that I last saw h alive on Aug 26 19 45

Immediate cause of death Carcinoma of Lungs — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Cushman M.D.

Address 1946 W North Ave Date signed 8/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

631854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

631854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Norfolk ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 27 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Norfolk ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Fanny Katz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Wid.

6 (b) Name of husband or wife Rud. Marcus Katz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70	—	—	hr. — min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Max Schulman
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Fanny Katz
(b) Address 3714 Forest Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)
(c) Cemetery or crematory Druedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 W. Baltimore St Huntington Williams, W.Va.

19 (a) 8-26 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Aug 23 1945, and that I last saw her alive on Aug 23 1945.

Immediate cause of death Arteriosclerosis Coronary occlusion — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Benjamin Kadet M. D.
Address 7306 Eastwood Rd Date signed 8-25-45

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631855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

631855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Gwynns Falls Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BLUM

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-1235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife REBECCA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name HYMAN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name IRENE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 8-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location Phil Rd & Bowleys Lane

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO ST

19 (a) 26 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-45 19 at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1944 to 8/24 1945, and that I last saw him alive on 8/24 1945.

Immediate cause of death AC CORONARY INFARCTION — Duration

Due to HYPERTENSIVE CVHD ARTERIOSCLEROTIC CVHD

Due to GENERALIZED ARTERIOSCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mildred Applefeld Blum

Address 2511 Runnymeade Rd Date signed 8/26/45

PRESS WHITE PENCIL WITH UNREADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G31856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31856 Registered No. 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5502 Wayne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5502 Wayne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian A. Norton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1860

8. AGE: Years 85 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Boston Mass
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

MOTHER / FATHER

12. Name Hannibal D. Norton

13. Birthplace Maine

14. Maiden Name Ellen A Williams

15. Birthplace Boston Mass

16 (a) Informant Arthur H. Norton

(b) Address 5502 Wayne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 1945 (month) (day) (year)

(c) Cemetery or crematory Rock Creek

Location Washington D.C.

18 (a) Funeral director Harry M Armacost

(b) Address 4204 Ridgewood Ave

19 (a) (b) Registrar

G 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1945, at 1 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Aug 25 1945 and that I last saw h alive on Aug 24 1945

Immediate cause of death Coma of Stomach — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. C. Samuel M. D.

Address 4209 Gelston Dr Date signed Aug 26

X

G31857

G31857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Cold Spring Lane 2101
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County do
(c) City or town Govans
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME William F Sterling Sr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widow

6 (b) Name of husband or wife Mary E Sterling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 - 1866

8. AGE: Years	Months	Days	If less than one day
81	2	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name Unknown
	13. Birthplace Unknown
MOTHER	14. Maiden Name Unknown
	15. Birthplace Unknown

16 (a) Informant Estate of William F Sterling
(b) Address Govans Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/45 (month) (day) (year)
(c) Cemetery or crematory Nicholson Memorial
Location Govans Md

18 (a) Funeral director R L Hopkins
(b) Address Govans Md

19 (a) 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to Aug 26 1945, and that I last saw him alive on Aug 25 1945.

Immediate cause of death	Duration
Valvular heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Cutterman M. D.
Address 2324 Remington Ave Date signed 8/27/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8 26 1945

WEINRAUB

G31858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G31858 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 8 Monument St & Ruthland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 37

(e) Length of stay in Baltimore (yrs., mos., or days) 23 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 4800 Park Hgts Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Gertrude Weinraub

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race wh

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation wife

11. Industry or business

FATHER 12. Name Salman — Russia

13. Birthplace

MOTHER 14. Maiden Name Raphael — Russia

15. Birthplace

16 (a) Informant Benj Weinraub

(b) Address 4715 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)

(c) Cemetery or crematory Druid Hill Ave

Location

18 (a) Funeral director Jacob Levin Inc

(b) Address 1739 E. Balto St

19 (a) (Date rec'd by registrar) Registrar

AUG 26 1945 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945, to Aug 26 1945, and that I last saw her alive on Aug 26 1945.

Immediate cause of death Adenocarcinoma of rectum

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation November 1944

Major findings of operation: Adenocarcinoma of rectum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Bertha Rader M. D.

Address Sinai Hospital Date signed 8-26-45

G31859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH .107

G31859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden + Madison Sts.

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, 13 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1723 Durham St. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Earnest Cecil Keatts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of ~~husband~~ Father Cecil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1944

8. AGE: Years 1 | Months 13 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business Baby

FATHER 12. Name Cecil Keatts

13. Birthplace Va.

MOTHER 14. Maiden Name Spealdin

15. Birthplace Va.

16 (a) Informant Cecil Keatts

(b) Address 1723 Durham St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/26/45 (month) (day) (year)

(c) Cemetery or crematory

Location Waynesboro, Va.

18 (a) Funeral director E. D. Fanning & Son

(b) Address 1938 E. Lafayette Ave.

19 (a) AUG 27 1945 (b) Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1945, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1945 to Aug 25 1945, and that I last saw h[illegible] alive on Aug 25 1945.

Immediate cause of death	Duration
Respiratory failure	2 hrs.
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dudley Phillips M. D.

Address Md. Gen. Hosp. Date signed 8/25/45

X

VS 150

G31860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 56a

G31860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 maple Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Mabel Carlin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife David Carlin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23-890

8. AGE: Years 54 | Months 11 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm J. B. Ilgenfritz
13. Birthplace Balto

MOTHER
14. Maiden Name Amelia Christ
15. Birthplace Balto

16 (a) Informant Wm O. Ilgenfritz
(b) Address Yeadon Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) 8-27-1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1945 at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1945 to Aug. 25 1945 and that I last saw h... alive on Aug. 25 1945

Immediate cause of death	Duration
Uremia – Peritonitis	10 days
Due to	
Due to	
Other Conditions Ovarian Cyst	

(Include pregnancy within 3 months of death)
Date of operation 8/7 and 8/22/45
Major findings of operation: Cystadenoma
Xray – Peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Juan Noguera M.D.
Address Md. Gen. Hosp. Date signed 8/28/45 M. D.

X

G31861 ✓ G31861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Orlean s
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael P Stuprich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Magdalena Stuprich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1880

8. AGE: Years	Months	Days	If less than one day
65	7	11 12	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Machinist retired
11. Industry or business

FATHER
12. Name Peter Stuprich
13. Birthplace Hungary

MOTHER
14. Maiden Name Don't Know
15. Birthplace

16 (a) Informant Mrs Magdalena Stuprich
(b) Address 4024 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 27/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 27 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1945 at 12 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 43 1943 to Aug 24 1945, and that I last saw h[illegible] alive on Aug 23 1945.

Immediate cause of death Pulmonary Abscess (Ab) Cardio-Renal Insuff May 26 — | Duration 1943 — 1945 — 2 yrs —
Due to | | |
Due to | | |
Other Conditions | | |
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 3505 Date signed Aug 28 45

VS 180

G31862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G31862

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Hrs. 4 Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J Kuper Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Erica

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1921

8. AGE: Years 24 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Bakery Salesman

11. Industry or business Driver

FATHER
12. Name William J Kuper (Jr)
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Campanella
15. Birthplace Md

16 (a) Informant William J Kuper
(b) Address 1809 N Bond St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Aug 28 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 27 1945 (Date rec'd by registrar) **(b)** Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 45 19 , at 9, 45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Shock,
Traumatic Diaphragmatic Hernia.
Due to Fractured Pelvis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-45 at 7:20 P.M. 7/4
(b) Where did injury occur? EAST BOUNDARY ASHLAND AVE. MADELEY TURN TO G. N. ON BROADWAY
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? Yes.
(d) Means of injury: Driver, Fell out of truck + came under tire.

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed August 24/1945.

VS 151

G31863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. G31863

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 529 W. Berry St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Edney
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	negro	married

6 (b) Name of husband or wife Alice Mary Edney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1902

8. AGE: Years	Months	Days	If less than one day
43	7	7	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Willis Edney
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Eaans Rivers
15. Birthplace S. Carolina

16 (a) Informant Alice Edney
(b) Address 529 W. Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-45 (month) (day) (year)
(c) Cemetery or crematory Charleston S. C.
Location S. C.

18 (a) Funeral director George G. Nelson
(b) Address 1303 Presstman St

19 (a) (Filed by registrar) (b) Registrar

AUG 27 1945

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/45 19 , at 4:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1945, to 8-25 1945, and that I last saw h alive on 8-25 1945

Immediate cause of death (a) Pneumonia
(b) aortic aneurysm ?
Due to (a) Acid. Pneumonia
Due to
DISTAL FILANGES
Other Conditions Amputation + left [illegible]
2nd 3 fingers at hand [illegible]
(Include pregnancy within 3 months of death)

Duration
1
10 days (?)

Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard T. Kurland M.D.
Address University Hospital Balto. Md. Date signed 8/29/45

X

31864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G31864

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1937 E. Monument Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Isadore Fine

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Fine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, County, and state)

10. Usual Occupation Jeweler

11. Industry or business

FATHER	12. Name Abraham —
	13. Birthplace Russia
MOTHER	14. Maiden Name Eyd —
	15. Birthplace Russia

16 (a) Informant Abraham Fine

(b) Address 1937 E. Monument Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)

(c) Cemetery or crematory Levi Mt. Carmel

Location

18 (a) Funeral director Jos. Levin Inc

(b) Address 1123 E. Balto. St.

19 (a) AUG 27 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1945, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1945 to August 26 1945 and that I last saw h. alive on August 26 1945.

Immediate cause of death	Duration
Cardiac Failure	48 hrs.
Due to Shock & myocardial infarction	48 hrs.
Due to Peritonitis	48 hrs.
Other Conditions	

(Include pregnancy within three months of death)

Date of operation 8/11/45

Major findings of operation: stomach ulcers

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert Chasin M.D.

Address Sinai Hospital Date signed 8/26/45

VS 180

631865 ✓ 631865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 N. Carlton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Arthur Boone ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 27, 1945

8. AGE: Years | Months: 4 | Days: 24 | If less than one day: hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Arthur Boone
13. Birthplace Balto Md

MOTHER
14. Maiden Name Gertrude Brown
15. Birthplace Balto Md

16 (a) Informant Gertrude Brown
(b) Address 229 N. Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location .....

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Date received by registrar) AUG 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/1945 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1945 to 8/20 1945 and that I last saw her alive on 8/20 1945

Immediate cause of death: Bronchopneumonia — Duration —

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature W. B. Howell M. D.
Address 601 Park Ave Date signed 8/29/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46E

G31866 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 E. 33rd St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 62

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 N. Calvert
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Carrie Virginia Griffith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1862

8. AGE: Years	Months	Days	If less than one day
82	0	21	12 hr. 0 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name	Mr. James T. Griffith (d)
13. Birthplace	Pennsylvania
MOTHER 14. Maiden Name	Maria Logan (d)
15. Birthplace	Baltimore, Md.

16 (a) Informant Miss Dolly Griffith.
(b) Address 3314 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place
AUG 27 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26th. 1945, at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8th 1945, to Aug 26th 1945, and that I last saw h-x alive on Aug 26 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	4 days
Due to Carcinoma of Ileum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug. 13, 1945
Major findings of operation: Carcinoma of Ileum.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick Jr. M.D.
Address Union Memorial Hosp. Date signed Aug 26-45

VS 150

X

G31867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G31867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Lytle St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. University Pky.
(If rural-give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margie R. Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife Robt. R
Thomas P. Perkins 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	4	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Lt. Rennert
13. Birthplace Balto

MOTHER
14. Maiden Name Caroline Brauns
15. Birthplace France (Alsace Lorraine)

16 (a) Informant Deceased's T.P. Perkins, Jr.
(b) Address 235 Chancery Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar AUG 27 1945) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26- 1945 at 12 49 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10- 1945 to 8-26- 1945 and that I last saw h Sr. alive on 8-26 1945

Immediate cause of death	Duration
Hypertensive C-V. Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Ehrlich M. D.
Address 1218 Lytle St. Date signed 8-26-45

VS 150

G31868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G31868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution: Anderson Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Ridgewood Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina M. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Clifford C. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1863

8. AGE: Years	Months	Days	If less than one day
82	8 4	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William McKay
13. Birthplace Scotland

MOTHER
14. Maiden Name Grace Forrest
15. Birthplace Scotland

16 (a) Informant Mrs. Grace M. Ellinger
(b) Address 208 Ridgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 AUG 27 1945 (Date Rec'd by Local Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1945, at 2.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 17 1945 to August 24 1945, and that I last saw h[illegible] alive on August 24 1945.

Immediate cause of death Cardio-Respiratory Failure

Due to Cerebral Hemorrhage
Coronary Thrombosis

Due to Arteriosclerotic Vascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Moreland E. Day M. D.
Address 2734 St. Paul St. Date signed August 26 1945

VS 150

G31869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. 27th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charlotte Spatz

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Ulysses C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1859

8. AGE: Years	Months	Days	If less than one day
86	6	9	hr. min.

9. Birthplace Windsor Township York Co. Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Gohn
13. Birthplace Windsor Township York Co. Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Hester Barnett
(b) Address 405 E. 27th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Freysville Cem.
Location Freysville Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1945, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Imbriaki M.D. Medical Examiner.
Date signed 8/26/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 631870

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2545 Francis St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2545 Francis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen M. Kable, Sr.

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. 213-05-4940

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret E. Kable

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1895

8. AGE: Years 49 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Jefferson Co., W. Va.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business U. S. Veterans Adm. Ft. Howard

FATHER
12. Name Clarence C. Kable
13. Birthplace Jefferson Co., W. Va.

MOTHER
14. Maiden Name Ida May Miller
15. Birthplace Jefferson Co., W. Va.

16 (a) Informant Mrs. Margaret E. Kable
(b) Address 2545 Francis St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/ /45 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 27 1945 (Delivered by registrar) **(b)** Registrar

MEDICAL CERTIFICATION

50

20. DATE OF DEATH August 25 19 45 at 6 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulderig M.D.
Medical Examiner.
Date signed 8-25-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G31871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W.
(b) Street address 1833 Lanvale St.
(c) Hospital or institution:

16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALIE GRAHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Robert M. Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1879

8. AGE: Years	Months	Days	If less than one day
66	6	7	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Armiger
13. Birthplace Unknown

MOTHER
14. Maiden Name Sunderland
15. Birthplace Unknown

16 (a) Informant Mrs. Lillian Graham
(b) Address 1833 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 AUG 27 1945 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1944 to Aug. 23 1945.
and that I last saw h[illegible] alive on Aug. 23 1945.

Immediate cause of death Cardiac Asthenia — Duration 3 days
Due to Hypertrophy of heart — 3 years
Due to Mitral insufficiency — 6 yrs
Other Conditions General Edema — 1 mo
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Franklin W. Shorb M. D.
Address 718 N. Fulton Ave. Date signed 8-28-45

VS 150

G31873 ✓ G31872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1413 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde V. Mayes (Mayes)

3 (b) If veteran, name war World War I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	married

6 (b) Name of husband or wife Nellie Mayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Van Mayes
13. Birthplace Va

MOTHER
14. Maiden Name Lana M Wilson
15. Birthplace Va

16 (a) Informant Floyd Mayes (Bro)
(b) Address 1413 N Fayette St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)
(c) Cemetery or crematory Hagerstown Md
Location

18 (a) Funeral director Robert L Brooks
(b) Address 1338 Hollins Street

19 (a) AUG 27 1945 (Date rec'd by registrar)
Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mussen M.D.
Medical Examiner.
Date signed August 26, 1945.

VS 151

Copies are especially important. Physicians: please write the causes of death clearly and legibly.

HEP #94569 631873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

307

631873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 21
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Joseph Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1860

8. AGE: Years	Months	Days	If less than one day
85	6	27	hr. min.

9. Birthplace Jamaica (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Burke (D)
13. Birthplace Jamaica

MOTHER
14. Maiden Name Katherine ??
15. Birthplace Jamaica

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 27 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1945, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4, 1945 to Aug. 25, 1945, and that I last saw him alive on Aug. 25, 1945.

Immediate cause of death	Duration
Aortic aneurysm	
obstruction esophagus &	
Cause left main bronchus	
Due to Syphilitic vascular disease	
Other Conditions Cachexia and malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: not obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address JCH Date signed 8/25/45

X

G31874 ✓ G31874

JO #89673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Haven St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Eder or Charles Eader

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21, 1868

8. AGE: Years	Months	Days	If less than one day
77	5	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frances Ader
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary K. Franz
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Co.
Location E. North Ave Ext

18 (a) Funeral director Leo G. Brook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Aug 27 1945 (Date received by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5, 1944 to Aug. 25, 1945 and that I last saw him alive on Aug. 25, 1945.

Immediate cause of death: Uremia — Duration ?
Due to: Hypertensive Cardiovascular Disease — Duration ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: none
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 8-29-45

VS 150

X

G31875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G31875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Wyeth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Mary Birmingham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1944

8. AGE: Years	Months	Days	If less than one day
	11	0	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name James Birmingham
13. Birthplace

MOTHER
14. Maiden Name Florence Marsh
15. Birthplace

16 (a) Informant Family
(b) Address 85 Calvert St

17 (a) D (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director J. A. Cauley
(b) Address 150 E. Fort Ave.

19 (a) AUG 27 1945 (b) Registrar Huntington Hollins, M.D.
(Month) (day) (year) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1945, at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1945 to Aug 24 1945 and that I last saw h.E.R. alive on Aug 24 1945

Immediate cause of death	Duration
Circulatory Failure	
Due to Gastroenteritis	
Due to	
Other Conditions Acidosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry W. Camp M. D.
Address Mercy Hosp. Date signed 8/24/45

VS 150

KEB #95306 G31876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Hutchins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1914

8. AGE: Years 31 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Hutchins
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella May Morris
15. Birthplace Maryland

16 (a) Informant: Baltimore City Hospitals records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. G. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 27 1945

49 190

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945 1945, at 8:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8, 1945 to Aug. 23 1945, and that I last saw her alive on Aug. 23, 1945.

Immediate cause of death: Pneumonia — Duration: 5 days

Due to: Overexpn of chest — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: Overexpn of thoracic cavity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 8-27-45

X

631877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

631877 / 128

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 Aisquith St.
(c) Hospital or institution: _____
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Aisquith St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Elizabeth Berkley Wright

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1898

8. AGE: Years	Months	Days	If less than one day
46 47	11	6	_____ hr. _____ min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER — 12. Name	Willie Watt
FATHER — 13. Birthplace	N. C.
MOTHER — 14. Maiden Name	Rosie Graves
MOTHER — 15. Birthplace	N. C.

16. (a) Informant Rosie Pinner
(b) Address 1012 Aisquith St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. & O.

18. (a) Funeral Director Palmer Sanders
(b) Address 1412 E. Preston St.

19 (a) _____ (Date rec'd by registrar) (b) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1945 at 9:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Suppurative Pancreatitis

Due to _____

Other Conditions Fatty degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury _____ at _____ M.
(b) Where did injury occur? _____
(c) Did injury occur at home, on farm, industrial place, in public place? _____ While at work? _____
(d) Means of injury _____

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed August 23, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31878

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

G31878

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Pinewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Pinewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Schirmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3 - 1891

8. AGE: Years	Months	Days	If less than one day
54	1	22	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Lumber Mfgr

FATHER 12. Name Henry G. Schirmer

13. Birthplace Md.

MOTHER 14. Maiden Name Catharine Nagengast

15. Birthplace Md.

16 (a) Informant Mrs. Schirmer

(b) Address 2913 Pinewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto.

18 (a) Funeral director L. J. Keyser

(b) Address 5805 Harford Rd.

AUG 27 1945
(Date rec'd by registrar)

(by) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1945, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 25 1945, and that I last saw h.l. alive on August 24 1945.

Immediate cause of death Respiratory Failure — Duration 24 hrs.

Due to Decompensation — 5 Months

Due to Hypertensive Arteriosclerotic Vascular Disease — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Donnell, M.D.

Address 2301 York Rd Date signed 8/31/45

B2150 #4 X

VS 150

G31879

JO #94212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 261
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Farrell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 18[illegible]64

8. AGE: Years	Months	Days	If less than one day
80 91	9	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

MOTHER | FATHER

12. Name Michael Farrell (d)
13. Birthplace Maryland
14. Maiden Name Catherine ?
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director L. J. Cusick
(b) Address 5305 Harford Rd.

19 (a) AUG 27 1945 (Date received by registrar) (b) for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16, 1945 to Aug. 25, 1945 and that I last saw him alive on Aug. 25, 1945.

Immediate cause of death	Duration
Coronary + Cerebral Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 8-27-45

VS 150

X

631880

Wheat

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 631880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore, 18 (If outside city or town limits, write RURAL and give town)

(d) Street No. 1761 Homestead St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3 (a) FULL NAME Mrs. Mary E. Wheat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married, Widowed

6 (b) Name of husband or wife Edward Wheat

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1864

8. AGE: Years 61 Months 2 Days 13 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Rudolph Muncher

13. Birthplace

MOTHER 14. Maiden Name Mary Ulrich

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Virginia Starkey

(b) Address 1761 Homestead St., City 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/45 (month) (day) (year)

(c) Cemetery or crematory Balto.

Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son

(b) Address 1938 E. Lafayette Ave.

19 (a) AUG 27 1945 (Local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 23 1945 to August 24 1945, and that I last saw her alive on August 24 1945.

	Duration
Immediate cause of death Carcinomatosis	
Due to Carcinoma of cervix Uteri	2 yrs.
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Frank Supplee, M.D.

Address Union Memorial Hosp. Date signed 8/24/45

VS 190

G31881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Edmondale (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Arran Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles F. Kistler

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth L. Kistler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1904

8. AGE: Years	Months	Days	If less than one day
41	1	10	hr. min.

9. Birthplace Slatesdale, Pa. (Town, county, and state)
10. Usual Occupation Lineman
11. Industry or business Gas & Elec. Co.

FATHER
12. Name William Kistler
13. Birthplace Pa.

MOTHER
14. Maiden Name Lillie Shefler
15. Birthplace Pa.

16 (a) Informant Mrs. Ruth L. Kistler
(b) Address 919 Arran Rd., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 27 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 45 at 1:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-45 at 1 A. M. 3/1
(b) Where did injury occur? Gas & Elec. Co. Employee - Room #: 1621 E. Baltimore St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Electrocuted.

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed August 26, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. 631882

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Clifton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Viola Reese

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Clarence A. Reese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Hecht Bros.

FATHER
12. Name Franklin W. Ruckle
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Ella May Lineweaver
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Alice R. Todd
(b) Address Ambassador Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 27 1945 (Date rec'd by registrar) (b) Beatrice for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1945 at 7 50 PM

21. I certify that I took charge of the remains described above, held an S T O thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph G Sherbow M.D.
Medical Examiner.
Date signed 8/25/45

VS 151

631883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186a

Registered No. 631883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Hollen Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C. Callis

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethelyn E. Callis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1899

8. AGE: Years 45 yrs | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Sales Mgr.

11. Industry or business: Anderson Oldsmobile Co.

FATHER
12. Name: James Cockrell Callis
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Madeline I. Gisriel
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Ethelyn E. Callis
(b) Address: 617 Hollen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem
Location: Baltimore Maryland

18 (a) Funeral director: WILLIAM J. TICKNER & SONS
(b) Address: Baltimore Maryland

19 AUG 27 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945 at 7:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhage, Traumatic, intra thoracic & abdominal

Due to: Thoracic & abdominal

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24 at 4/ 11.48 P.M.
(b) Where did injury occur? Emerson Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from fire escape

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 8-25-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G31884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G31884 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Frederick A. Casaleggi

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-3049

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lula Casaleggi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1879

8. AGE: Years: 66 | Months: 4 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual Occupation: Retired — machinist

11. Industry or business: Francis A. Hock Co.

FATHER
12. Name: Antonio Casaleggi
13. Birthplace: Italy

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. William M. Conway, Jr.
(b) Address: 19 N. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross Cem.
Location: Brooklyn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 27 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25/1945 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/1945 to 8/25/1945, and that I last saw him alive on 8/25/1945.

Immediate cause of death: Fracture of Femur
followed by Pneumonia — Duration: 1 mo.
Due to: — Duration: 16 days
Due to:
Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation 7/20/45
Major findings of operation: Non union of fragments
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 4/1
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence 8/30/44 at 10 M
(c) Where did injury occur? 308 E. Pratt St. Balto. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial place (Specify type of place) While at work? Yes
(e) Means of injury: Fell from ladder

23. Signature: Chas. Norton Jr. M.D.
Address: Bon Secours Hosp. Date signed 8/26/45 M. D.

Howard J. Andersen, M. D.-X

VS 150

631885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. 631885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 N. Pallish St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 N. Pallish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Simpson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907 - 5 - 13

8. AGE: Years	Months	Days	If less than one day
38	3	11	hr. min.

9. Birthplace Ellicott City, Md.
(Town, county, and state)
10. Usual Occupation laborer.
11. Industry or business

FATHER
12. Name Isaac Simpson
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden Name Cornelia Hampton
15. Birthplace Md.

16 (a) Informant Mrs. Alexander Daniels
(b) Address 1529 W. Hamment Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St. Huntingtown Hill Sta. Md.

AUG 27 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 19 45 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20/45 19 to 8/24 19 45 and that I last saw h[illegible] alive on 8/24 19 45

Immediate cause of death Cerebral Thrombosis — Duration 3 mos.
Due to
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. W. Reckling, M.D.
Address 426 N. Johns St. Date signed 8/27/45

VS 150

631886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 631886

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dix
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): DOA
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Jesse Horace Cooper

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife: Bessie -
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-17-1882

8. AGE: Years	Months	Days	If less than one day
63	-	9	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business:

FATHER
12. Name: A. J. Cooper
13. Birthplace: Md.

MOTHER
14. Maiden Name: Nancy ?
15. Birthplace: N. C.

16 (a) Informant: Bessie Cooper (Wife)
(b) Address: 215 W Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-45 (month) (day) (year)
(c) Cemetery or crematory: Mt Zion
Location: Md

18 (a) Funeral director: Adolph Halstead
(b) Address: 918 [illegible]

19 (a) AUG 27 1945 Registered by: Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1945, at 12:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: H. J. Williams M.D.
Medical Examiner.
Date signed 8/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G31887

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 E. 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. M. Aiken

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8299

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Mary Aiken

6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) May 15, 1908

8. AGE: Years 37 | Months 3 | Days 10 | If less than one day ____hr. ____min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Truck Driver.

11. Industry or business Elite Laundry.

FATHER
12. Name John W. A. Aiken
13. Birthplace

MOTHER
14. Maiden Name Elda Marshall
15. Birthplace Md.

16 (a) Informant Mary Aiken
(b) Address 337 E 21st St.

17 (a) Burial (b) Date thereof Aug 29 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Manchester
Location Manchester Md

18 (a) Funeral director Jacob Winkelmann
(b) Address Manchester Md.

19 AUG 27 1945 Huntington Williams Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945, at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-23-45 at 9:45 P.M.
(b) Where did injury occur? Linden Ave. & Hoffman St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed August 26, 1945.

G31888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G31888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wilkins & Caton Aves

(c) Hospital or institution: St. Agnes Hospital '27-14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da

(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4301 Roland Ave Kirkleigh Villa (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Annie Lyons

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Michael J. Lyons

6 (c) If alien, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 15. 1866

8. AGE: Years 79 Months — Days 10 If less than one day hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Christian Henry Smith

13. Birthplace Virginia

MOTHER 14. Maiden Name Julia L. Beyer

15. Birthplace Maryland

16 (a) Informant Mrs. E.C. Murray

(b) Address 115 Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) AUG 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1945, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945 to 8/25 1945, and that I last saw h CH alive on 8/25 1945.

	Duration
Immediate cause of death: Fractured Hemorrhage	
Due to: nasal malignancy	
Due to: Pulmonary Intestinal Obstruction	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas Roberts Jr. M. D.

Address St. Agnes Hosp Date signed 8/27/45

VS 150

X

G31889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Liberty Heights Ave
(c) Hospital or institution: 1500

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Silber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 22, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	4	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business Bakery Business

FATHER
12. Name Solomon Silber
13. Birthplace Austria

MOTHER
14. Maiden Name Rose Kandel
15. Birthplace Austria

16 (a) Informant Dora Silber
(b) Address 4000 Liberty Heights Ave

17 (a) Burial (b) Date thereof Aug 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 9 7 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION 5.50

20. DATE OF DEATH August 26 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 19 to 8/26 1945, and that I last saw h alive on 8/26 1945.

Immediate cause of death Coronary artery sclerosis — Duration 5 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester B King M. D.
Address 2904 Eastern Ave Date signed 9/7/45

VS 150

31890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland & Laynes

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4920 Denmore ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Hayes

3 (b) If veteran, name war: World war I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: May Parkey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1888

8. AGE: Years 57 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Baltimore Transit Co

FATHER 12. Name Charles Hayes

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lucy V. Thomas

15. Birthplace Fairfax County Va

16 (a) Informant Mrs May Hayes

(b) Address 4920 Denmore ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-29-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Loving Bush Funeral Home

(b) Address 500 N Pine Heights ave Baltimore 23 Md

AUG 27 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945, at 5:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 26 1945 to Aug 26 1945, and that I last saw h. alive on Aug 26 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Vascular Accident	
Due to Hypertension & Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Baltimore

Address Med Baltimore General Date signed Aug 27 1945

631891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

G31891
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State MD. (b) County PARKVILLE MD
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 155 High Point Road & Taylor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME THOMAS NUNZIO BONOMO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 19, 1942

8. AGE: Years	Months	Days	If less than one day
2	10	7	hr. min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name JOSEPH LEO BONOMO
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name CATHERINE Ferranti
15. Birthplace MARYLAND

16 (a) Informant Joseph Leo Bonomo (Father)
(b) Address High Point Rd. Parkville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/45 (month) (day) (year)
(c) Cemetery or crematory St. Vincent
Location Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) [illegible] Washington Williams, M.D. (Registrar)
AUG 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to Aug 26 1945 and that I last saw him alive on Aug 25 1945

Immediate cause of death	Duration
CEREBRAL ATROPHY	
Due to ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gayle B. Arnold M. D.

Address U.M.H. Date signed 8-26-45

X

G31892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877

G31892

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 E. 21st Balt. 18, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Sally C. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 11/30 years

7. Birth date of deceased (mo., day, yr.) ~~Nov. 30~~ 1893

8. AGE: Years	Months	Days	If less than one day
52	8	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business

FATHER
12. Name James M. Carroll
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lola Barker
15. Birthplace Baltimore

16 (a) Informant Mrs. J.W. Wagner
(b) Address 326 E. 21st Balt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location City

18 (a) Funeral director Harry G. Wiedefeld
(b) Address 601 East 32nd St.

19 (a) Filed (b) Received by registrar Herrington Williams, M.D. Registrar
8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1945, at 1200 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1945 to 8/25 1945, and that I last saw her alive on 8/24 1945

Immediate cause of death	Duration
Respiratory Paralysis	
Due to Multiple Sclerosis	84 mo's
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.H. Bailey M. D.
Address Mercy Hosp. Date signed 8/25/45

X

631893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

631893 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Buscombe Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Buscombe Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Madeleine Romaine Le Moyne Elliott

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Chas Ellis Elliott
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 14 1855

8. AGE: Years	Months	Days	If less than one day
89	9	11	hr. min.

9. Birthplace Illinois
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John F Le Moyne
13. Birthplace Washington Pa.

MOTHER
14. Maiden Name Julia Murray
15. Birthplace West River Md

16 (a) Informant Chas. Ellis Elliott
(b) Address 2407 Buscombe Lane

17 (a) Aug 28 1945 (Burial, cremation, or removal) (b) Date thereof Aug 28 1945 (month) (day) (year)
(c) Cemetery or crematory Elliott (Private)
Location Ellicott City Md

18 (a) Funeral director Henry W Kahmann & Son
(b) Address 11 McCulloh & Eutaw Sts

19 (a) 8/28/1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1942 to 8/25 1945, and that I last saw h[er] alive on 8/25 1945.

Immediate cause of death Coronary Thrombosis — Duration 10 days
Due to Arteriosclerosis
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Murray Fisher M.D.
Address 18 E. Eager St. Baltimore Date signed 8/26/45

VS 180

G31894

CWK-95606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31894 ✓ 107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 0- 6- 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 S. Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Nauton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10-1945

8. AGE: Years	Months	Days	If less than one day
0	6	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy Nauton
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Clara E. Reckline
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location a.a. Co.

18 (a) Funeral director A. Howard Evans
(b) Address 1460 Gilmor St. Baltimore, Md.

AUG 27 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27- 1945, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1945 to Aug. 27 1945, and that I last saw her alive on Aug. 27 1945.

Immediate cause of death Bronchelitis

Due to

Due to

Other Conditions Infected Eczema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Caylor M. D.
Address Balt. City Hosp. Date signed 8/27/45

X

360813 G31895 BALTIMORE CITY HEALTH DEPARTMENT ✓ G31895
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spiros Procopis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation merchant seaman
11. Industry or business

FATHER
12. Name Spiros Procopis
13. Birthplace Greece

MOTHER
14. Maiden Name Arsino
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros Funeral Home Inc.
(b) Address 438-440 E. Fayette

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-26-1945 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-1945 to 8-26-1945 and that I last saw him alive on 8-26-1945.

Immediate cause of death: Cardiac failure
Due to: Hypertensive and Arteriosclerotic heart disease
Due to: Posterior myocardial infarction
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dean
Address Johns Hopkins Hospital 8/26/45

VS 150

G31896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 or 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard W. Herbert

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ora E Herbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21. 1874

8. AGE: Years 71 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Hagerstown Md (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Richard Herbert

13. Birthplace Hagerstown Md

MOTHER 14. Maiden Name Charlotte Webster

15. Birthplace Felair Md

16 (a) Informant Ora E Herbert

(b) Address 1509 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)

(c) Cemetery or crematory Mouland Park

Location Baltimore Md

18 (a) Funeral director Wilhelm Sons

(b) Address 1217 E Fayette St

19 (a) AUG 28 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945, at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to Aug. 26, 1945. and that I last saw him alive on Aug. 26, 1945.

Immediate cause of death Cerebral Hemorrhage & Left Hemiplegia. — Duration 3 weeks

Due to Arteriosclerosis — Duration 3 Yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin E Singewald

Address 1613 E. North Ave Date signed 8-28-45.

VS 189

G31897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G31897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Chestnut Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Hallie C. Clark

3 (b) If veteran, name war: ND
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James B. Clark
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 12th 1890
8. AGE: Years 54 Months 8 Days 14 If less than one day hr. min.
9. Birthplace Churchtown Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business O'Neill Dept. Store

FATHER
12. Name Amos Kelley
13. Birthplace Md.

MOTHER
14. Maiden Name Hallie Smith
15. Birthplace Md.

16 (a) Informant J. B. Clark Jr
(b) Address 601 Missula Rd Towson Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1417 St. Paul St.
19 AUG 28 1945 (Date rec'd by registrar) (Signature of registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1945, at 7:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 8/26 1945, and that I last saw her alive on 8/24 1945

Immediate cause of death — Duration

Acute Lymphatic Leukemia — 6 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Martin E. Hurst M.D.
Address Maryland General Hospital Date signed 8/26/45

VS 150

X

G31898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G31898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 N. Bentalou
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 847 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James D. Snowell

3 (b) If veteran, name war Yes | 3 (c) Social Security Account No. 219-46-9318

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Maria Louisa Snowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3. 1866

8. AGE: Years 79 | Months 6 | Days 23 | If less than one day: hr. min.

9. Birthplace Thurmont Md. (Town, county, and state)

10. Usual Occupation Agent Motor Patrol

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Catherine McGuigan
15. Birthplace Unknown

16 (a) Informant Albert L. Snowell
(b) Address 847 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Our Lady of Mt. Carmel
Location Raymond Md.

18 (a) Funeral director Wilhorn Bros
(b) Address 1267 W. Lanvale St.

19 (a) AUG 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945, at 6 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1943 to Aug. 26, 1945
and that I last saw him alive on Aug. 25, 1945

Immediate cause of death: Carcinoma of sigmoid — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 8/27/45

VS 150

G31899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1210

G31899
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 322 Woodlawn Rd

(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 322 Woodlawn Rd
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Frank Milleare Bolgiano

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Ella Bolgiano

6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) April 26 1866

8. AGE: Years	Months	Days	If less than one day
79	4	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business -

FATHER

12. Name Francis Bolgiano

13. Birthplace Balti. Md

MOTHER

14. Maiden Name Sarah Ebaugh

15. Birthplace Baltimore Md

16 (a) Informant Mr. F. Sylvester Smith (Son in law)

(b) Address 4 Hillside Road

17 (a) Burial (b) Date thereof Aug 30 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem.

Location Baltimore Md

18 (a) Funeral director Edward Mooney Co.

(b) Address 1401 W Baltimore St.

19 (a) AUG 28 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1945, at 8.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944, to Aug. 27, 1945.

and that I last saw h[illegible] alive on Aug. 27, 1945

Immediate cause of death Chronic Nephritis — Duration over a year

Due to — Duration

Due to — Duration

Other Conditions Hypertension — Duration over a year

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: -

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide -

(b) Date of occurrence - at - M

(c) Where did injury occur? -
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? - While at work?
(Specify type of place)

(e) Means of injury -

23. Signature Frank H. Ogden M. D.

Address 2701 N. Calvert St. Date signed Aug. 28, 45

VS 180

631900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

Registered No. 631900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Belvedere Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM EMMEL

3 (b) If veteran, name war
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Emmel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1854

8. AGE: Years	Months	Days	If less than one day
91	5	1	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business retired

FATHER
12. Name Conrad Emmel
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Konrad
15. Birthplace Germany

16 (a) Informant Mrs. Wm. Emmel
(b) Address 1702 Belvedere Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Lutheran
Location Balto., Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) AUG 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24, 1945 at 8:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb'y 1943 to Aug'st 24 1945 and that I last saw h[illegible] alive on Aug'st 24 1945

Immediate cause of death Carcinoma of liver — Duration unknown
Due to — Duration
Due to — Duration
Other Conditions Encephalopathy arteriosclerosis — Duration unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Emmel
Address 4808 Harford Rd. Date signed 8/28/45

VS 150

G31901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G31901

JO #48661

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5yr.11mos.1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 S. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Cawley

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Roderick (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1888

8. AGE: Years	Months	Days	If less than one day
57	05	07	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Taylor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Ulrich
15. Birthplace Baltimore, Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore

18 (a) Funeral director Philip Henry Lord
(b) Address 2124 Orleans St

19 AUG 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1945, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25, 1939 to Aug. 26, 1945, and that I last saw h. alive on Aug. 26, 1945.

Immediate cause of death	Duration
Aspiration of food followed by massive atelectasis	
Due to multiple sclerosis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jonathan Hoveland M. D.
Address B. C. H. Date signed 8/27/45

X

1902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 631902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 919 N Arlington Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 919 N Arlington Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Caroline Carter Caroline Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Major

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1853

8. AGE: Years 52 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Va

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Gabriel Crawley

13. Birthplace Va.

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant Caroline Carter

(b) Address 919 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md

18 (a) Funeral director Geo. H. Kelson

(b) Address 1303 Pressman St

19 (a) Date received by Registrar AUG 29 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1945, at 7:55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 26 1945, to Aug 26 1945, and that I last saw h[illegible] alive on Aug 26 1945.

Immediate cause of death

Pulmonary Edema

Due to Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Long

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible]

Address 2 W Lanvale

M. D.

Date signed 8/26/45

631903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 631903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 E. Balto. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jankiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Ludwika
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business B. + O. Railroad

FATHER
12. Name Joseph
13. Birthplace Poland

MOTHER
14. Maiden Name Frances
15. Birthplace Poland

16 (a) Informant Ludwika Jankiewicz
(b) Address 2522 E. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) AUG 28 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26th 1945 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/6th 1945 to 8/26th 1945 and that I last saw him alive on 8/20th 1945

Immediate cause of death	Duration
Cardiac Failure	3 weeks
Due to Carcinoma of Stomach	2.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jankiewicz M. D.
Address 100 N. Milton ave Date signed 8/28/45

VS 150

100 N. Milton ave Mo 3930

G31904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G31904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 W. Lex. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Byrd. Jr. 321725

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Marry.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/45

8. AGE: Years | Months: 5 | Days: 5 6 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER 12. Name: Robert Byrd. Sr.

13. Birthplace: N.C.

MOTHER 14. Maiden Name: Nevada Gullis

15. Birthplace: Va.

16 (a) Informant: Walter Byrd.

(b) Address: 1507 W. Lex. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary

Location: A. Halsted

18 (a) Funeral director: A. Halsted

(b) Address: 916 N. Druid Hill Ave.

19 (a) AUG 28 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/ 1945 at 1 W 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1945 to 8/28 1945 and that I last saw h. alive on 8/27/ 1945

Immediate cause of death: Lt lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Haddleone M. D.

Address 1131 Harlem Signed 8/28/45

X

VS 150

G31905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

V 13/a

G31905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 S. Tremont Rd.
(c) Hospital or institution:

28-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 S. Tremont Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. FREESE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Fanny G. Freese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	9	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Retired Engineer
11. Industry or business Dept. Public Education

FATHER
12. Name Frederick Freese
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace w

16 (a) Informant Mrs. Charles T. Freese
(b) Address 102 Tremont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar for Williams M.D.

AUG 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 1945, at 5:50P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to Aug 24 1945, and that I last saw h[illegible] alive on Aug 22 1945.

Immediate cause of death Cardio-vascular renal disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 504 Hud Ave Date signed 8/27/45
M. D.

X

G31906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G31906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison

(c) Hospital or institution: Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2504 Manhattan Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Clara M. James

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander R. James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1873

8. AGE: Years: 72 Months: 6 Days: 22 If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER

12. Name: Charles Crisp

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden Name: Mary Wales

15. Birthplace: Balto., Md.

16 (a) Informant: Mr. Alexander R. James

(b) Address: 2504 Manhattan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge Cem.

Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Balto., Md.

19 (a) AUG 28 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1945 to 8-27 1945 and that I last saw her alive on 8-27 1945

Immediate cause of death	Duration
Hemorrhage - Cachexia	
Due to Carcinoma of the Cervix uteri	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature O. M. Caudell M. D.

Address Md Gen. Hosp. Date signed 8-27-45

VS 150

G31907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31907
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 W. Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Gerwig

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No. 215-07-6205

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theo E. Gerwig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/1894

8. AGE: Years 50 | Months 9 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Bethlehem Fairfield IB Co.

FATHER
12. Name Jacob F. Gerwig
13. Birthplace Howard, Maryland

MOTHER
14. Maiden Name Mary A. Mannion
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Theo. E. Gerwig
(b) Address 1801 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 28 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1945, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereof and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Andrews M.D.
Medical Examiner.
Date signed Aug. 27, 1945

X

G31908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5508 Wayne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5508 Wayne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Witteman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ella Witteman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1864

8. AGE: Years	Months	Days	If less than one day
80	8	13	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Retired Piano Finisher
11. Industry or business

FATHER
12. Name Christopher J. Witteman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Scherer
15. Birthplace Germany

16 (a) Informant Amelia M. Witteman
(b) Address 5508 Wayne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry N. Armacost
(b) Address 4204 Ridgewood Ave

19 (Aug 28 1945) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1945 at 11 02 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1945, to Aug 27 1945, and that I last saw him alive on Aug 27 1945.

Immediate cause of death	Duration
Pericardial Hemorrhage	Instt.
Due to Ch. myocarditis	10 yrs.
Arteriosclerosis	10 yrs.
Due to Ch. nephritis	10 yrs —
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo Schlenger
Address 4600 Liberty Hts. Date signed 8/28/45

VS 150

X

G31909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31909 Registered No.

1170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Bageley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Grace Bageley

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) August 5, 1902

8. AGE: Years 43 | Months - | Days 20 | If less than one day hr. min.

9. Birthplace Blackstone, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Nannie Marshall

15. Birthplace

16 (a) Informant Grace Bageley

(b) Address 1735 Orleans Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bradstley Ave

19 (a) (b) Huntington W. Virginia, Registrar

AUG 28 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1945, at 2:55 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Multiple fractures, abrasions and bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-24-45 at 10:50 P. M. 6/5

(b) Where did injury occur? Orleans & Broadway

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Pedestrian - Struck by Auto

23. Signature Howard L. Walker M.D. Medical Examiner.

Date signed August 26, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3533-46631910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. 631910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily E Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife Clyde Jennings
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 9-2-04

8. AGE: Years	Months	Days	If less than one day
40	11	23	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Frank Norris
13. Birthplace Va

MOTHER
14. Maiden Name Martha Crockett
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloom & Lexington ave

19 (a) AUG 28 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1945 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1945 to 8-25- 1945 and that I last saw her alive on 8-25- 1945

Immediate cause of death Hemorrhage, intestinal

Due to Contributed to by carcinoma cervix

Due to Ureters III

Other Conditions Recto vaginal fistula

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan MD
Address 607 N. Broadway Date signed 8-26-45

VS 150

Huntington Williams MD
Huntington Williams MD

G31911

G31911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 E. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 E. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arinette Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female Col.

5. Color or race

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1908

8. AGE: Years 37 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Benjamin Smith

13. Birthplace Md

14. Maiden Name Mary Williams

15. Birthplace Md

16 (a) Informant Julia Smith

(b) Address 1901 Sapp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Cabery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bfanstley Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945, to Aug 24 1945, and that I last saw her alive on Aug 23 1945

Immediate cause of death Acute respiratory failure — Duration

Due to Chronic pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert E. Burwell

Address 171 Arlington Ave Date signed 8/25/45

X

G31912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. G31912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore-11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Huntington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife ? Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1891

8. AGE: Years	Months	Days	If less than one day
54	0	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas J. Barnett
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. Forenberg
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Frederick Squires
(b) Address 224 E. 4th St. Mt. Royal Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Putnam Highway

18 (a) Funeral director John F. Conrad & Son
(b) Address 201-03 E. Baltimore St.

19 (a) AUG 28 1945 (Date of death) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1945, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/1945, to 8/27/1945 and that I last saw her alive on 8/27/1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Carcinomatosis	
Due to	
Other Conditions Colostomy.	

(Include pregnancy within 3 months of death)

Date of operation 8/14/45

Major findings of operation: Carcinomatosis generalized (primary site? Thought to be Sigmoid)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizedek Spragins M.D.
Address U. M. H. Date signed 8-27-45

SPRAGINS

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G31913

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 7 N Linsley St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 7 N Linsley St (If rural route location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William H. Mc-Laughlan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jessie J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1886

8. AGE: Years	Months	Days	If less than one day
58	5	12	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Steam Fit

11. Industry or business Shipyard Inc

MOTHER / FATHER

12. Name Thomas Mc-Laughlan

13. Birthplace Ireland

14. Maiden Name Sarahann Leslie

15. Birthplace Ireland

16 (a) Informant Jessie J. Mc-Laughlan

(b) Address 7 N Linsley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29-45 (month) (day) (year)

(c) Cemetery or crematory Medowridge Mem Park

Location Washington Road

18 (a) Funeral director John E Moran

(b) Address 3600 E Baltimore St

19 (a) Huntington Williams, Mgr (Date rec'd by registrar) Registrar

AUG 28 1945

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 17 1945 to Aug 26 1945, and that I last saw h[illegible] alive on Aug 26 19 45

Immediate cause of death Carcinoma of Lung.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation no operation

of autopsy: none

Duration
7
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm Kelly M. D.

Address 100 N Linwood Ave Date signed Aug 27 45

G31914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31914 Registered No. 1160c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Loudon & Madison

(c) Hospital or institution: Md. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 502 Lyndhurst St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard E. Becker.

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1945

8. AGE: Years | Months | Days | If less than one day: 2 hr. 30 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Howard A. Becker

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Victoria H. Appleby

15. Birthplace Baltimore, Md.

16 (a) Informant Howard A. Becker

(b) Address 502 Lyndhurst St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director J. Howard Strong

(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945, at 1 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1945 to 8/28 1945, and that I last saw h.m alive on 8/28 1945.

Immediate cause of death: Atelectasis (either primary or

Due to aspiration of amniotic fluid)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 hrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.

Address 1738 E. 28th St. Date signed 8/28/45

X

G31915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31915 Registered No.

JO #95609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Earl Plank

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1900

8. AGE: Years	Months	Days	If less than one day
45	-1-	21	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unable to obtain information.
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace Europe

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) AUG 28 1945 (b) Date rec'd by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1945, at 12:30M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1945, to Aug. 26, 1945, and that I last saw him alive on Aug. 26, 1945.

	Duration
Immediate cause of death Generalized Peritonitis	Hours
Due to Carcinoma of Splenic flexure of colon & perforation	?
Due to Carcinoma of Colon - Acute intestinal obstruction	10 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8/23/45
Major findings of operation: Carcinoma of colon
of autopsy: Carcinoma & Perforation

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Penny M.D. M. D.
Address Balto City Hosp. Date signed 8/27/45

X

G31916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G31916

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greene & Lombard Sts

(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Belfast Road (If outside city or town limits, write RURAL and give town) Baltimore, Md Timonium

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Raymond R. Rittenour

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1904

8. AGE: Years	Months	Days	If less than one day
41	7	22	hr. min.

9. Birthplace Fisher Hill, Virginia (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business

FATHER

12. Name Joseph Rittenour

13. Birthplace Va.

MOTHER

14. Maiden Name Fannie Rebrencap

15. Birthplace Va.

16 (a) Informant (Sister) Ada Riggin

(b) Address 24 Alleghany Ave Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27 1945 (month) (day) (year)

(c) Cemetery or crematory River View

Location Hagerstown Md

18 (a) Funeral director Frederick F. Cole

(b) Address 1205 W. Lombard St

19 (a) (Date received by Registrar) AUG 28 1945 (b) Registrar Huntington Indiana, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1945 at 9:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1945 to 8-25 1945 and that I last saw h. alive on 8-25 1945

Immediate cause of death Respiratory failure

Due to Possible CVD heart pancreas

Due to Pulmonary Carcinoma of liver

Other Conditions Hemorrhoids

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Not done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D. Clark M. D.

Address University Hosp Date signed 8-25-45

G31917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G31917

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1718 E. Oliver St

(c) Hospital or institution: at Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1718 E. Oliver St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Joseph W. Reilly

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Mary Ellen McMahon Reilly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25 1862

8. AGE: Years	Months	Days	If less than one day
83	5	3	hr. min.

9. Birthplace Baltimore Md (town, county, and state)

10. Usual Occupation Retired Lady

11. Industry or business Employee

FATHER

12. Name James Reilly

13. Birthplace Ireland

MOTHER

14. Maiden Name Not Known

15. Birthplace Ireland

16 (a) Informant Mrs Hall (Daughter)

(b) Address 1718 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Cathedral Cem. Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Conklin Son (b) Address 945 E. Eager St.

19 (a) (Date rec'd by registrar) AUG 28 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1945 at 11:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days

Due to: Gen. arteriosclerosis & Hypertension — Duration: indefy.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Myron D. Boyko, M. D.

Address 1626 N. Caroline St. Date signed 8-28-45.

VS 180

631918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

631918
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1851 Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert P. Vermillera
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married (common law)

6 (b) Name of husband or wife Gertrude Vermillera
6 (c) If alive, give age 42 years
7. Birth date of deceased (mo., day, yr.) Jan 6 - 1898

8. AGE: Years	Months	Days	If less than one day
47	7	20	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Robert Vermillera
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude
15. Birthplace Va.

16 (a) Informant Chas Vermillera
(b) Address 324 S Eastern

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Elkridge

18 (a) Funeral director Leidrick Funeral Home
(b) Address 2005 Orleans St

19 (a) Aug 28 1945 (Date received by registrar) (b) Huntington Woll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26 1945 at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1945 to 8/26 1945 and that I last saw h/ alive on 8/26 1945.

Immediate cause of death Coronary occlusion
Due to Infarction
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rezitt M. D.
Address St. Agnes Hosp Date signed 8/27/45

VS 190 Certificate to be taken by Undertaker to Vital Statistics Office for Approval

631919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

631919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Hayward Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Hayward Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE T. HOFFMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Albert Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	0	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Interior Decorator
11. Industry or business Hochschild, Kohn & Co.

FATHER
12. Name ? Ritler
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Miss May D. Hoffman
(b) Address 3720 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 28 1945 (Date received by Registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1945, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945. to Aug 27 1945.
and that I last saw h[illegible] alive on August 27 19 45.

Immediate cause of death Hypertension vs. Cardio vascular Renal disease vs Arteriosclerosis — Duration 10 yrs

Due to

Due to

Other Conditions Parkinsonian Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. T. Lowman M. D.
Address 5013 Park Heights Ave. Date signed 8-28-45

X Lowman

G31920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. G31920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 E. 33rd St.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Dennison St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ~~Mrs. John M.~~ Harned (Carrie E.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife John M. Harned

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 17-1877

8. AGE: Years 64 | Months 3 | Days 9 | If less than one day 5 hr. 00 min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

PARENTS

12. Name Charles A. Campbell

13. Birthplace Massachusetts

MOTHER

14. Maiden Name Emily J. Hyman

15. Birthplace Pennsylvania

16 (a) Informant John M. Harned

(b) Address 2420 Dennison St - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-45 (month) (day) (year)

(c) Cemetery or crematory Walton

Location Walton New York

18 (a) Funeral director Walter C. Fuller Funeral Home

(b) Address 2735 E. Oliver St

19 AUG 29 1945 (Date rec'd by registrar) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1945, to 19 , and that I last saw h alive on 8/28 1945.

Immediate cause of death Respiratory Failure

Due to Carcinoma of thyroid & extension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Decker M. D.

Address Union Mem. Hosp. Date signed 8/28/45

VS 150

631921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 524 S Chapel Gate Lane

(c) Hospital or institution: Center Lodge

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 13

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 S Compton St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Amanda E Gable

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1863

8. AGE: Years 81 | Months 9 | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Frank Orem

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs H Ward

(b) Address 122 Riverside Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc

(b) Address 1217 E Fayette St

19 (a) AUG 29 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945, to Aug 28 1945, and that I last saw h[illegible] alive on 8/28 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage.	20 days
Due to Hemiplegia	20 days
Due to Oedema Brain.	6 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 1279 Williams Date signed 8/28/45 M. D.

VS 150

G31923 ✓ G31922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Guilford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE E. TARBERT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	None	female	white	married

6 (b) Name of husband or wife John A. Tarbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	3	hr. min.

9. Birthplace Bedford, Virginia
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Albon T. Falls
13. Birthplace Virginia

MOTHER
14. Maiden Name Orie C. Rusher
15. Birthplace Virginia

16 (a) Informant John A. Tarbert
(b) Address 2007 Guilford Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 (a) AUG 29 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1941 to Aug 27 1945, and that I last saw her alive on Aug 27 1945.

Immediate cause of death	Duration
Carcinomatosis	
Oesophagus - rectal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M. D.
Address 508 E. North Ave. Date signed 8/29/45 M. D.

VS 190

X

631923 ✓ 631923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4817 Laurel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4817 Laurel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Stiefel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Minnie A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1881

8. AGE: Years	Months	Days	If less than one day
63	11	10	hr. min.

9. Birthplace New York.
(Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER
12. Name John Stiefel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace N. Y.

16 (a) Informant Conrad Stiefel
(b) Address 4817 Laurel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

19 (a) AUG 29 1945 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945; at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to August 1945, and that I last saw h[illegible] alive on Aug 28 1945.

Immediate cause of death Angina Pectoris

Due to Arterio Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 8/26/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Bucket M. D.
Address 1 E Pleasant St Date signed 8/29/45

VS 150

G31924 — 32 — G31924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 W. Fayette st.
(c) Hospital or institution: 181
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Timothy Clough

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1945

8. AGE: Years	Months	Days	If less than one day
	7	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Timothy Clough
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Elizabeth Fox
15. Birthplace Md.

16 (a) Informant Elizabeth Clough
(b) Address 1221 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Pellham Lockard
(b) Address 1294 Pratt St

19 (a) AUG 29 1945 (Date rec'd by registrar) (b) Huntington Willis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1945 to Aug 27 1945 and that I last saw h[illegible] alive on Aug 26 1945.

Immediate cause of death Enteritis — Duration Mos. 3 hrs. 40.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scarpetta M. D.
Address 1724 W. Lombard St. Date signed Aug 28 45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Chucri Zablah ✓

631925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

631925 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Tegucigalpa (If outside city or town limits, write RURAL and give town)
(d) Street No. Paz Barahona ave (If rural, give location)
(e) Citizen of foreign country? Central Am (Yes or No)
If yes, name country Honduras

3 (a) FULL NAME Chucri Zablah

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emilia D. de Zablah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-02

8. AGE: Years	Months	Days	If less than one day
42	8	3	hr. min.

9. Birthplace Palestine (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Jorge Zablah
13. Birthplace Palestine

MOTHER
14. Maiden Name Sara Jacoman
15. Birthplace Palestine

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory TEGUCIGALPA
Location TEGUCIGALPA, HONDURAS

18 (a) Funeral director Wilson Co Inc
(b) Address 1219 Eutaw

19 (a) AUG 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945 at 2.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to Aug 27 1945 and that I last saw him alive on Aug 27 1945

Immediate cause of death Cachexia - Uremia — Duration

Due to Chronic Nephritis — 15 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurie Duckett M.D.
Address Johns Hopkins Hosp Date signed 8/29

VS 150

31926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G31926

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 River Side Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bridges

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.: No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-45

8. AGE: Years | Months | Days | If less than one day: 2 hr. 0 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Y. B. Bridges
13. Birthplace Cedartown, Georgia

MOTHER
14. Maiden Name Thelma Lois Edwards
15. Birthplace Cedartown, Georgia

16 (a) Informant Thelma Bridges (Mother)
(b) Address 322 Riverside Rd.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 29 1945 (Date rec'd by registrar) Hunter Jr. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1945, at 11:53 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1945 to 8-27 1945, and that I last saw him alive on 8-27 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity (30 Weeks)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 8-28-45

VS 150

2926

G31927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G31927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sylvia Marie Temple

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-45

8. AGE: Years | Months | Days 2 | If less than one day: 24 hr. min.

9. Birthplace Md (town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Henry Temple
13. Birthplace Md.

MOTHER
14. Maiden Name Delores Temple
15. Birthplace Md.

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 29 1945 (Date rec'd by registrar) (b) Harold J. Mitchell, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1945 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to Aug 20 1945 and that I last saw h[illegible] alive on Aug 20 45.

Immediate cause of death: Respiratory Failure — Duration
Due to: ? Cerebral Hemorrhage
Due to:
Other Conditions: Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elgin Everett Batson
Johns Hopkins Hos - Assistant Resident
Address p.o. al Date signed 8/21/45

VS 150

2925

X

G31928 ✓ G31928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 N. Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee Joshua

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Joshua
13. Birthplace Florida

MOTHER
14. Maiden Name Hallie Mitchell
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 29 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1945, at 5:47A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1945, to Aug. 9 1945, and that I last saw him alive on Aug. 9 1945.

Immediate cause of death	Duration
intracranial hemorrhage	
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Voobaugh M. D.
Address Date signed

VS 160

2924

355787
G31929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G31929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Maryland~~ New York County
(c) City or town Amsterdam
(If outside city or town limits, write RURAL and give town)
(d) Street No. 263 Division Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William Greenspan (Wm. Greenspan)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Anna Greenspan
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 2-16-1894

8. AGE: Years	Months	Days	If less than one day
51	6	12	..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Jacob Greenspan
13. Birthplace Poland

MOTHER
14. Maiden Name Jussie Seigel
15. Birthplace Poland

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sons of Israel
Location Amsterdam, N. Y.
18 (a) Funeral dir. Harris Sonnenstein Son
(b) Address 1902 Eutaw Place
19 (a) 8-29-1945 (b) Huntington Williams Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1945 at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1945 to 8-28 1945; and that I last saw h[illegible] alive on 8-28 1945.

Immediate cause of death Pulmonary Embolism — Duration
Due to Thrombophlebitis Post Operative
Due to
Other Conditions Monilia Carcinoma
(Include pregnancy within 3 months of death)
Date of operation 8-9-45 and 8-23-45
Major findings of operation Carcinoma of Bronchus
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. A. Cooley M. D.
Address The Johns Hopkins Hospital Date signed 8-28-45

631930

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

✓ 631930
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Shirley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sherman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name William Sherman
13. Birthplace Md

MOTHER 14. Maiden Name Rita Alfinito
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29-45 (month) (day) (year)
(c) Cemetery or crematory Park Wood
Location Taylor Ave Parkville Md
18 (a) Funeral director Frank Della Nave
(b) Address 524 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 AUG 29 1945 Huntington Hillsman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1945 at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to Aug 27 1945 and that I last saw h[illegible] alive on Aug 27 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to ? Aspiration at vomitus	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Batson M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 8/28/45

X

G31931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

✓ G31931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Adele Pasek

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Carl Pasek
6 (c) If alive, give age 9, 1919 years

7. Birth date of deceased (mo., day, yr.) August 21, 1920

8. AGE: Years 25 Months 26 Days 16 6 If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Stachowski
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rose Jankowski
15. Birthplace Baltimore Md.

16 (a) Informant Carl Pasek
(b) Address 407 S. Wolfe St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 30 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director Reilly & Zeiler inc.
(b) Address 403 S Wolfe st.

19 (a) [illegible] AUG 29 1945 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1945, at 7.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1945, to August 25 1945; and that I last saw her alive on Aug 25 1945.

	Duration
Immediate cause of death: Uremia	?
Due to: Intercalation of Kidney	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry W. Camp M. D.
Address Mercy Hosp. Date signed 8/25/45

X

JO 63055 G31932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G31932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. & 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Lassiter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Edith (d.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1885

8. AGE: Years	Months	Days	If less than one day
60	-1-	-9-	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Odd jobs
11. Industry or business

FATHER
12. Name Henry Holland
13. Birthplace North Carolina

MOTHER
14. Maiden Name Martha Lassiter
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director Walter J. Jackson
(b) Address 916 Penna ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 AUG 29 1945 Burlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1945, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1943 to Aug. 26, 1945, and that I last saw him alive on Aug. 26, 1945.

	Duration
Immediate cause of death: Cardiac failure	7
Due to: Hypertensive arteriosclerotic Heart disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 8-26-45 M. D.

G31933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md Va (b) County
(c) City or town Norfolk Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia (State, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Lippa Milner Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Maurice Miller
(b) Address 407 Raleigh Ave - Norfolk Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk Va

18 (a) Funeral director Jake Lewis Inc
(b) Address 139 E Balto St

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945, at 6:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1945, to Aug. 28 1945, and that I last saw h alive on Aug. 28 1945.

	Duration
Immediate cause of death Cardiac Failure	2 weeks
Due to Hypertensive Cardio-vascular disease	
Due to arteriosclerosis	20 yrs
Other Conditions Benign Prostatic Hypertrophy	1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Chanin M.D.
Address Sinai Hospital Date signed 8/29/45

G31934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G31934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5105 Palmer Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Palmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Friedel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Philip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 22.1878

8. AGE: Years	Months	Days	If less than one day
66	10	6	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Beryl Frankel
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude
15. Birthplace Russia

16 (a) Informant Samuel Friedel
(b) Address 311 Cathedral St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 30, (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by registrar) (b) AUG 29 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to 8-28 1945, and that I last saw her alive on 8-27 1945

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard J. Cohen M. D.
Address [illegible] Date signed 8-29-45

X

G31935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G31935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Park ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Park ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Margaret Murphy
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 28, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	29	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name John Murphy
13. Birthplace Newcastle, Del.

MOTHER
14. Maiden Name Margaret O'Donohue
15. Birthplace Washington D.C.

16 (a) Informant Miss Josephine Mann
(b) Address 708 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/45 (month) (day) (year)
(c) Cemetery or crematory Sew Cathedral
Location Balto Md.

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address McCulloh & Eutaw Sts

AUG 29 1945 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 9:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 16 1945, to August 27 1945, and that I last saw h[illegible] alive on August 27 1945.

Immediate cause of death Cerebral vascular accident — Duration (most)
Due to Hypertension — embarrass
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Frances W Gluck
Address 715 Park ave Date signed 8/28/45 M. D.

VS 150

631 Price

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 631936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 314 N. Ann St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 314 N. Ann St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Lee Price Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1895

8. AGE: Years	Months	Days	If less than one day
50 49	8	2	hr. min.

9. Birthplace Stanly N. Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER

12. Name Mark Price

13. Birthplace N. C.

MOTHER

14. Maiden Name Mollie Taylor

15. Birthplace N. C.

16 (a) Informant Bessie Price

(b) Address 314 N. Ann St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 29/45 (month) (day) (year)

(c) Cemetery or crematory

Location Littlestown N. Carolina

18 (a) Funeral director Mr. Robert M. Elliott

(b) Address 1118 N. Carolina St.

19 (a) AUG 29 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1945 at 10 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to Aug 26 1945, and that I last saw him alive on Aug. 24 1945.

Immediate cause of death Cardiac muscular disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R. M. Purnell M. D.

Address 1422 E. Chase Date signed 8-28-45

VS 150

TG31937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G31937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3138 Cliftmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3138 Cliftmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: George B. Schutz

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie M. Schutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1877

8. AGE: Years 68 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Christopher Schutz
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Elizabeth--
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs Lillie M. Schutz
(b) Address: 3138 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31/45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Sturm Sons
(b) Address: 2024 Orleans St.

19 (Date received by local registrar) AUG 29 1945 Huntingtor Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28/45 19 , at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Aug 28 1945, and that I last saw h me alive on Aug 27 1945.

Immediate cause of death: Chronic myocarditis Congestive heart failure — Duration: 5 yrs 2 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Edwin Mooney M. D.
Address 3105 Belair Rd Date signed 8-29-45

VS 150

G31938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 E.Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 E.Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Jubb

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Thomas Jubb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.25,1864

8. AGE: Years	Months	Days	If less than one day
81	6	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ### ---- Hanshaw
13. Birthplace Md.

MOTHER
14. Maiden Name ----
15. Birthplace Md.

16 (a) Informant Mr.Raymond Jubb
(b) Address 2406 E.Fayette St.

17 (a) Burial (b) Date thereof Aug.30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) AUG 29 1945 (b) Huntington Williams, M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug.27th/45 19 ; at 5-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19th 1945 to Aug 27 1945 and that I last saw h alive on Aug 27th 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 9 days
Due to Generil Arteriosclerosis — 2
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Faulkner M. D.
Address 1 0 N. Mullory Date signed 8/29/45

X

G31939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G31939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1hr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Presstman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Countess

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-9760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Joseph Countess
13. Birthplace Md.

MOTHER
14. Maiden Name Julia Darsey
15. Birthplace Md.

16 (a) Informant Mary Moore
(b) Address 1501 Presstman st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) (Date received by registrar) AUG 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1945, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 8/30/45

VS 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be obtained or correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31940 CMK-95587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59 B

G31940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 52- 9- 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 Brunt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Alexander

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Maria Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15 - 1892

8. AGE: Years	Months	Days	If less than one day
52	9	12	hr. min.

9. Birthplace Baltimore- Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Alexander
13. Birthplace Virginia

MOTHER
14. Maiden Name Louise Johnson
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (month) (day) (year)
(c) Cemetery or crematory St Peters cem.
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) AUG 29 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1945, to Aug. 27 1945, and that I last saw him alive on Aug. 27 1945

Immediate cause of death	Duration
Gangrene of Right Foot	13 yrs
Due to Generalized arteriosclerosis	more than 13 yrs
Due to	
Other Conditions Chronic atrophic arthritis	

(Include pregnancy within 3 months of death)

Date of operation 0
Major findings of operation: 0
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto City Hosps Date signed 8-28-45

97

G31941

G31941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3543 - 6th St., Brooklyn
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3543 - 6th St. - Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Florence Jabrow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Edw. Jabrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1869

8. AGE: Years 76 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Luther Quade
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Clarence Jabrow
(b) Address 3543 - 6th St. - Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Brooklyn

18 (a) Funeral director Welsh Funeral Home
(b) Address 2004-08 Orleans St.

19 (a) (b) Huntington Williams M.D. Registrar

AUG 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1945, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1945 to Aug 27 1945 and that I last saw him alive on Aug 27 1945

Immediate cause of death Acute Dilatation of heart — Duration 2 days

Due to Mitral Regurgitation & Aortic Stenosis — Duration Indef.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 164 W. Lemmon St. Date signed 8/29/45

G31942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G31942 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Harford Rd
(c) Hospital or institution: Murray Jones Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6028 Harford Rd (If rural route location)
(e) Citizen of foreign country 4108 Gardenia Drive (Yes or No)
If yes, name country

3 (a) FULL NAME John Kitz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Christina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1866

8. AGE: Years 79 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Martin Kitz
13. Birthplace Germany

MOTHER 14. Maiden Name Mrs Joseph Keller
15. Birthplace ?

16 (a) Informant Mrs Jos Keller
(b) Address 14 N Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cath
Location

18 (a) Funeral director Leeper-Bennett Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 29 1945 (Date rec'd by registrar) Registered by Wm [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Died death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wallis M.D. Medical Examiner.
Date signed Aug. 29, 1945

VS 151

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

G31943
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Frederick Road
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Churchville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Wechter (Mary C. Wechter)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Arthur W. Wechter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 - 1856

8. AGE: Years	Months	Days	If less than one day
88	8	18	hr. min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Shertzer
13. Birthplace Lancaster Co. Pa

MOTHER
14. Maiden Name Elizabeth Yessell
15. Birthplace Lancaster Co. Pa

16 (a) Informant Miss. Elizabeth Shertzer
(b) Address Aberdeen Md, R.F.D. #2

17 (a) Removal (b) Date thereof Aug. 21 - 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nefferville Lutheran
Location Nefferville Pa.

18 (a) Funeral director Henry Fenney & Son
(b) Address Aberdeen Md

19 (a) (Date received by registrar) (b) Registrar
AUG 29 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1945 at 11 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11 1945 to 8-28 1945, and that I last saw h alive on 8-28 19 45.

Immediate cause of death Carcinoma

Due to Generalized abdominal Ca

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-13-45

Major findings of operation: Generalized abdominal carcinoma

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerald E Roush
Address Md. General Hospital Date signed 8/28/45

G31944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Simpson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1883

8. AGE: Years 62 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Md.

16 (a) Informant John Chapman
(b) Address 2823 Simpson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 30 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Palmer Sanders
(b) Address 1412 E. Preston St.

AUG 29 1945 (Date received by Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1945, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Jacket thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio - vascular Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Knudsen M.D.
Medical Examiner.
Date signed August 27, 1945.

G31945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G31945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline Ave.

(c) Hospital or institution St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 745 N. Patterson Park Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Frank J. Piver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	D.

6 (b) Name of husband or wife Antonetta Piver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/87

8. AGE: Years	Months	Days	If less than one day
57	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name Frank Piver

13. Birthplace Bohemia

MOTHER 14. Maiden Name Antonetta Elsler

15. Birthplace Bohemia

16 (a) Informant Antonetta Piver

(b) Address 745 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director Frank Brockton

(b) Address 900 N. Chester St

19 (a) AUG 29 19 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/46 19 , at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14/46 19 , to 8/28/46 19 , and that I last saw him alive on 8/28/46 19 .

Immediate cause of death Cardiac paralysis

Due to Accident.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. A. Rodgers M. D.

Address St. Joseph's Hosp. Date signed 8/29/46

VS 180

G31946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn Park, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Parmelee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marion E.
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 12 - 28 - 88

8. AGE: Years	Months	Days	If less than one day
56	9	29	hr. min.

9. Birthplace Rochester, Minn.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business General Contracting

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Marion E. Parmelee
(b) Address Old Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/43 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director Walter J. Flannery Inc
(b) Address 745 Light St.

19 (a) AUG 29 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1943; at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1943; to 8/27 1943; and that I last saw him alive on 8/27 1943;

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Not yet complete

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel
Address Md. Gen. Hospital Date signed 8/27/43 D.

VS 190

G31947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G31947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Canary Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Canary Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles K. Foos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Foos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30-1871

8. AGE: Years	Months	Days	If less than one day
73	10	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Oyster Shucker
11. Industry or business

FATHER
12. Name Conrad Foos
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Margaret Foos (Wife)
(b) Address 2217 Canary Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/45 (month) (day) (year)
(c) Cemetery or crematory Schwartz's Cem.
Location O'Donnell St.

18 (a) Funeral director John F. Miller
(b) Address 2034 Jefferson St.

19 AUG 29 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1945, to Aug. 25 1945, and that I last saw h[im] alive on Aug 25 1945.

Immediate cause of death Uraemia

Due to Chr. Nephritis & Chr. Hypertension

Due to

Other Conditions Encapsulated adhesions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Greenfield M.D.

Address 700 E. Fayette St. Date signed Aug 29 45

G31948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

G31948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia V. Eder

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edward J.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20 1866

8. AGE: Years: 79 | Months: 7 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: John B. Tolley
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Lamsden
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Wm B. James
(b) Address: 2314 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Old Frederick Rd.

18 (a) Funeral director: M.W.E. Dippel Sons
(b) Address: Lombard & Ann Sts

19 (a) AUG 29 1945 Registrar
(b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to Aug 28 1945, and that I last saw h 4 alive on Aug 28 1945.

Immediate cause of death: Carcinoma of left breast — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Albert Eberhart M.D.
Address: 230 Eutaw Pl Date signed: 8/30/45

X

631949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

631949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Mo. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Dunleer Rd # 22
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Underwood

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 205-10-9399

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Lucia W Underwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	18	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Vice Pres.

11. Industry or business Patapsco & Back River R. R.

FATHER
12. Name Henry H. Underwood
13. Birthplace England

MOTHER
14. Maiden Name Maria C. Kuhns
15. Birthplace Pa.

16 (a) Informant Mrs. Lucia W. Underwood
(b) Address 3005 Dunleer Rd., Dundalk

17 (a) Removal (b) Date thereof 9/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenwood Cem.
Location Lancaster, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

AUG 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945 at 12:58 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1945 to Aug 29 1945 and that I last saw h(im) alive on Aug 28 1945.

Immediate cause of death	Duration
Cerebral Vascular Collapse	
Due to Uremia, Edema	
Due to Congestive Heart Failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dudley Pudlyn M.D.
Address [illegible] Date signed 8/29/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

631950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Robb St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Robb St. #18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Cord, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	217-01-0214

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Zernadia M. Cord
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	8	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Sexton Stove Co.

FATHER
12. Name Edward Cord
13. Birthplace Hardford Co. Md.

MOTHER
14. Maiden Name Harris
15. Birthplace Hardford Co. Md.

16 (a) Informant Mrs. Zernadia M. Cord
(b) Address 2015 Robb St.

17 (a) Burial (b) Date thereof 8/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grove Presby Cemetery
Location Aberdeen Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) (Date rec'd by registrar) (b) AUG 29 1945 Registrar

VS 154 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/45 1945, at 10:15 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Aug. 27 1945 and that I last saw him alive on Aug 25 1945.

	Duration
Immediate cause of death [illegible]	[illegible]
Due to Angina Pectoris	2 years
Due to Carcinoma Sclerosis Generalized	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 215 E. Preston St. Date signed 8/29/45

X

G31951

AB-94386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G31951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos. 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 13- 1931

8. AGE: Years	Months	Days	If less than one day
13	11	15	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Stewart (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Simms
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31. 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.Co. Md.

18 (a) Funeral director Isaiah L. Brown Son
(b) Address 1015 W. Montgomery Street

19 (a) (Postmaster to fill in) (b) Huntingtown Calvert Co. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28- 1945 at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26-45 1945, to 8-28- 1945, and that I last saw her alive on 8-28- 1945.

	Duration
Immediate cause of death Miliary Tuberculosis	
Due to	2 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Miliary Tuberculosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. E. Bayliss M. D.
Address Balt. City Hosp. Date signed 8/31/45

US-150

X

G31952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G31952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143 Siegward Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 Siegward Lane
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME John J. Klinefelter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena Becker
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1879

8. AGE: Years	Months	Days	If less than one day
66	6	19	---hr. -- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business P. Flanigan & Sons

FATHER
12. Name Jeremiah Klinefelter
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Jane Anderson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. John J. Klinefelter
(b) Address 143 Siegward Lane, Irvington

17 (a) Burial (b) Date thereof 8/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (AUG 29 1945) Registrar Irvington Woods Baltimore Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945 at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 8/28 1945, and that I last saw him alive on 8/28 1945

Immediate cause of death Chronic Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alvin H. Lennartson M. D.
Address 47 09 2nd Ave Date signed 8/29/45

VS 180

631953

479389.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 631953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town Louisville (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Raine Rum Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Rogers.

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fanny.
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 2-18-97.

8. AGE: Years	Months	Days	If less than one day
48	6	10	hr. min.

9. Birthplace Ky. (Town, county, and state)
10. Usual Occupation Cabinet Maker.
11. Industry or business

FATHER 12. Name Charles Elliott Rogers.
13. Birthplace Ky.

MOTHER 14. Maiden Name Frances Robertson
15. Birthplace Ky.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (burial, cremation, or removal) (b) Date thereof 8/29/45 (month) (day) (year)
(c) Cemetery or crematory Louisville
Location Louisville Ky

18 (a) Funeral director Oldham Brook Co.
(b) Address 1319 Lo Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-28 1945 at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-27 1945 to Aug-28 1945, and that I last saw h alive on Aug-28 1945.

Immediate cause of death	Duration
Failure of Cardiovascular System	30 hrs
Due to Probably brain tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-27-45
Major findings of operation: Increased intracranial pressure
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Young M. D.
Address Johns Hopkins Hospital Date signed 8-28-45

X

G31954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G31954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1654 DELANO COURT
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. #17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 DELANO COURT MOUNT ST NORTH OF PENNSYLVANIA AVENUE
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL JENNINGS (SHELIA OLIVIA JENNINGS)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race BLACK | 6 (a) Single, married, widowed, or divorced. INFANT

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUGUST 26, 1945

8. AGE: Years | Months | Days | If less than one day 14 hr. 30 min.

9. Birthplace BALTO. MD. #17 (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name RUBIN JENNINGS
13. Birthplace ROXBURY N. CAR.

MOTHER
14. Maiden Name SARAH SEBERRY
15. Birthplace DUNN, N. CAR.

16 (a) Informant SARAH JENNINGS
(b) Address 1654 DELANO COURT

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 29 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (c) AUG 29 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 28 1945, at 2:30 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death NOT KNOWN (CIRCULATORY OR RESP. FAILURE) BUT PROBABLY DUE TO — Duration

Due to 1) INTER CRANIEL HEMORRHAGE OR

Due to 2) CONGENITAL HEART & FAILURE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 8/29/45

2927

G31955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G31955 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Taneytown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Maurice Duttera

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/1/1868

8. AGE: Years	Months	Days	If less than one day
77	3	28	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Amos Duttera
13. Birthplace Penna.

MOTHER
14. Maiden Name Martha Babylon
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Methodist Cem.
Location Taneytown, Md.

18 (a) Funeral director Raymond F. Knight
(b) Address Woodbine Bridge Md.

9 1945 (b) Rec'd by registrar Huntington Williamsville, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1945 to Aug 29 1945 and that I last saw him alive on Aug 29 1945

Immediate cause of death	Duration
Coronary Thrombosis	½ hr.
Due to	
Due to	
Other Conditions Hemiplegia (2 mos.)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Milton Lindemuth M. D.
Address Mercy Hosp. Date signed 8/29

X

G31956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G31956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden Ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Falls Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Chirdon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 713-12-578

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Stella Chirdon.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 28, 1877

8. AGE Years	Months	Days	If less than one day
68	3	-	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Chirdon.
13. Birthplace Pa.

MOTHER
14. Maiden Name Levina Saltzgiver
15. Birthplace Pa.

16 (a) Informant Sarah L. Chirdon.
(b) Address 4415 Falls Road.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)
(c) Cemetery or crematory Altoona
Location Roaring Spring

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2615-17 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registered No.

29 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945 at 10 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to Aug 28 1945, and that I last saw him alive on Aug 28 1945.

Immediate cause of death Ca Cheruia

Due to Carcinoma of Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dudley Phillips
Address Madison + Linden Ave Date signed 8/28/45 D.

G31957

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

G31957
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yr. 10 mos. 3 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore City~~ Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Forest Hill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Dorothy Irene Holmes. (Dorothy Irene Holmes)
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-05-1206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 25, 1908

8. AGE: Years	Months	Days	If less than one day
36	10	3	hr. min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)
10. Usual Occupation Chief Telephone Operator
11. Industry or business C & P Telephone Co.

FATHER
12. Name Henry Holmes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise M. Stapf
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian Reich
(b) Address 3602 Forest Hill Road, Wdln

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lamborn
(b) Address 4510 Liberty Heights Ave.
Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945, at 3:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 8/28 1945.
and that I last saw her alive on 8/28 1945.

Immediate cause of death Cardiac Failure
due to Rheumatic heart disease

Duration 28 yrs.

~~Due to~~ Renal shutdown
due to chronic pyelitis

Due to Congestion

Other Conditions Hydrothorax, Rt
Bronchopneumonia, bilateral
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Richard Compton M. D.
Address Hospital for Women Date signed 28 Aug. 45

X

JL - 74049 G31958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31958 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 3 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriette Cheeseman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	2	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Cobb Isaac
13. Birthplace Penna.

MOTHER
14. Maiden Name Pheobe Hunter
15. Birthplace New Jersey

16 (a) Informant B. C. Hosp. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 '45 (month) (day) (year)
(c) Cemetery or crematory Balto Lawn
Location E North Ave Est

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park ave

AUG 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 19 45 at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 19 42 to Aug. 27 1945, and that I last saw h.. alive on Aug. 27 19 45.

Immediate cause of death [illegible] cerebral embolism
Due to multiple emboli from endocarditis
Due to
Other Conditions arteriosclerosis nephrosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Bedard M. D.
Address B. C. H. Date signed

VS 150

Substitute for Williams, M.D.

631959 ✓ 631959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Pemberton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hogan

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation
11. Industry or business RETIRED

FATHER 12. Name JOHN T. HOGAN
13. Birthplace IRELAND

MOTHER 14. Maiden Name KATE O KEEFE
15. Birthplace IRELAND

16 (a) Informant LEO HOGAN
(b) Address 813 WINSTON AVENUE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-31-45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director MARY M. WIEDEFELD
(b) Address 501 EAST 22ND STREET. (Huntington Williams Mgr.)

AUG 29 1945 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1945 at 4 43 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1945 to 8-28 1945, and that I last saw her alive on 8-28 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Cerebral Hemorrhage or	
Due to Thrombosis	
Other Conditions arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. C. Robertson M. D.
Address St. Joseph Hosp. Date signed 8-28-45

VS 180

X

GB1960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G31960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Galvansky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Rubin Galvansky
13. Birthplace Russia

MOTHER
14. Maiden Name Rosie ?
15. Birthplace Russia

16 (a) Informant Mrs Kate Gamse
(b) Address 4415 Pimlico Road

17 (a) Burial (b) Date thereof Aug. 30, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 Aug. 30 1945 (b) Huntington Millinery, M.D.
Date received by Local Reg. (Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 1945 to August 29 1945, and that I last saw h m alive on August 29 1945.

Duration

Immediate cause of death Uremia

Due to Hypertension, artero sclerotic heart disease

Due to

Other Conditions Congestive failure, bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Schecter, M. D.
Address Sinai Hospital, Balto, Md Date signed 8/29/45

X

G31961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, as it is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 Cumberland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENIA MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	3 29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Myers
13. Birthplace Baltimore, MD.

MOTHER
14. Maiden Name ? Sharp
15. Birthplace Md.

16 (a) Informant Mrs Bertha Harden
(b) Address 513 Cumberland St.

17 (a) Burial (b) Date thereof 8-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto., Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

AUG 30 1945
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, '45 19..., at 5P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20- 1945, to 8-27- 1945 and that I last saw her alive on 8-27- 1945

Immediate cause of death: cerebral hemorrhage — Duration 4 Hrs

Due to: hypertensive cardio-vascular-renal disease — 3 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Carr M. D.
Address 575 Mulberry St Date signed 8-29-45

VS 150

X

G31962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G31962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Spruson St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert F. Hausler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name ~~of husband~~ or wife Marion
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-15

8. AGE: Years	Months	Days	If less than one day
29	11	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Plasterer
11. Industry or business Armstrong Cont. Co.

FATHER
12. Name Otto Hausler
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara
15. Birthplace Md.

16 (a) Informant Marion Hausler
(b) Address 1930 Spruson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director F. A. Shipley & Son
(b) Address 852 W. Baltimore St.

19 (a) (Date received by Local Registrar) AUG 30 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945, to 8/28 1945, and that I last saw ~~him~~ her alive on 8/28 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary Edema	
Due to Tuberculosis meningitis	
Other Conditions Hyperthyroidism, Toxic Goiter, Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. Gill Jr. M.D.
Address St. Agnes Hosp. Date signed 8/28/45

VS 150

G31963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G31963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)

(d) Street No. 17 Seabright Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Victor G. Fruhling JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-5-45

8. AGE: Years	Months	Days	If less than one day
	6	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Victor G. Fruhling

13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Irene Lanocha

15. Birthplace Balto., Md.

16 (a) Informant Victor G. Fruhling (Father)

(b) Address 17 Seabright Ave Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location Hyman Hill Rd.

18 (a) Funeral director Charles S. Feiler

(b) Address 3605 Fait Ave.

AUG 30 1945 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945, at 3 65 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1945, to 8/28 1945, and that I last saw h[illegible] alive on 8/28 1945.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Empyema.

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation 8/15/45

Major findings of operation: Empyema

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Eugene J. Petry

Address 1400 N. Caroline St. Date signed 8-24-45

VS 150

G31964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G31964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. Front St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Front (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mannie Gioffre or Guffri

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~xxxxx~~ late Leo Gioffre

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1877

8. AGE: Years: 68 | Months: 6 | Days: 2 | If less than one day: hr. min.

9. Birthplace Termini Imerese Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Giuseppe De Luca
13. Birthplace Italy

MOTHER
14. Maiden Name Anastasia Cocilovo
15. Birthplace Italy

16 (a) Informant Vincent Garofalo (Son)
(b) Address 406 N. Front St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1st/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

AUG 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1945 to 8/29 1945, and that I last saw h[illegible] alive on 8/29 1945

Immediate cause of death: Acute cerebral Hemorrhage

Due to: Ch. Hypertention

Due to: Chronic arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Huntington Williams M.D.
Address 733 Argyle Ave. Date signed 8/29/45

631965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

631965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Mount Olivet Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phyllis Papale

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1873

8. AGE: Years	Months	Days	If less than one day
72	-	8	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Pace
13. Birthplace Italy

MOTHER
14. Maiden Name Augustine D. Amico
15. Birthplace Italy

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Boland Road

18 (a) Funeral director Joseph Faraone Inc
(b) Address 201 S Rhemont Ave

19 (a) AUG 30 1945 Registrar
(Date received)
Huntington Printing Co., Inc.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945, at 12 25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
arteriosclerotic cardio-vascular disease

Due to

Other Conditions Fractured femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury At M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland E. Foster M.D.
Medical Examiner.
Date signed Aug. 29 1945.

631966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 V

Registered No. 631966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Mulliman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Anna Henson

3 (b) If veteran, name war /

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Henry Henson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Sullivan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachael ?
15. Birthplace Md.

16 (a) Informant Mary Williams
(b) Address 1312 Ashland Ave

17 (a) Burial (b) Date thereof 9-2-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Antietam
Location Balto. Co.

18 (a) Funeral director Samuel McCullough
(b) Address 1717 N. Caroline Ave

19 (a) AUG 30 1945 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 19 45 - 10:10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Contributory

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-30-45

VS 151

931

G31967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G31967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address V
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Avon Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1944

8. AGE: Years	Months	Days	If less than one day
1	—	—	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Raymond Lane
13. Birthplace S.C.

MOTHER
14. Maiden Name Maggie Archie
15. Birthplace Chester S.C.

16 (a) Informant Eula Douglass
(b) Address 1001 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) AUG 30 1945 (Date received by Registrar) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Aug 28 1945 and that I last saw him alive on Aug 28 1945

Immediate cause of death	Duration
Preparatory failure	
Due to Pneumonia	
Due to	
Other Conditions Infectious Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Robinson M. D.
Address Univ. Hosp. Date signed 8-30-45

VS 150

G31968 G31968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Jenkins

3 (b) If veteran, name war: no
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~: Jodie Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1909

8. AGE: Years 35 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Parmele N.C.
(Town, county, and state)

10. Usual Occupation Hosiery mfg

11. Industry or business

FATHER 12. Name Mack Gaynor
13. Birthplace N.C.

MOTHER 14. Maiden Name Willie Ann
15. Birthplace N.C.

16 (a) Informant Mrs Ida Robertson
(b) Address 202 N. Fremont ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 31, 45 (month) (day) (year)

(c) Cemetery or crematory
Location Rocky Mount, N.C.

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Salisbury St.

AUG 30 1945 (Date rec'd by registrar)

(b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945 at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1945 to 8-28 1945, and that I last saw h[illegible] alive on 8-28 1945

Immediate cause of death: Intestinal obstruction.
Due to operation
Due to Fibroid uterus
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8-25-45
Major findings of operation: Fibroid uterus
of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr J F White for Dr M E Wilson M. D.
Address Provident Hosp Date signed 8-29-45

VS 150

G31969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31969
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Vine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Snead SNEAD.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife William Snead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1895

8. AGE: Years 50 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Northumberland Co, Va.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name James Tolson.
13. Birthplace Northumberland

MOTHER
14. Maiden Name Pattie Carpenter
15. Birthplace Northumberland Co. Va

16 (a) Informant Beatrice Taylor.
(b) Address 579 N. mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Hazel R. Williams
(b) Address 327 N. Schroeder St.

19 (a) (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1945, at 11 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 21 1945 to Aug. 26 1945, and that I last saw h[illegible] alive on Aug. 26 1945

Immediate cause of death Hypostatic Hemorrhage Duration 1 month
Due to Pulmonary Atherosclerosis
Due to Heart Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Rockley M.D.
Address 426 N. Gilmor Date signed 8/29/45

VS-150

G31970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G31970

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Hillen Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	

6 (b) Name of husband or wife Dora (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Henry Woods
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Va

16 (a) Informant Lucy Morris
(b) Address 2280 Bedford Ave. Brooklyn N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)

(c) Cemetery or crematory
Location Charlottsville, Va

18 (a) Funeral director Joseph B. Locke, Jr
(b) Address 130 E. Central Ave

19 (a) Huntington, W. Va. Registrar

AUG 30 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1945, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions Hypertrophy & dilatation of heart Generalized arteriosclerosis Chr. Nephritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 8-28-45

G31971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G31971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2605 Halcyon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** James Stewart Holland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Mary Nettie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20, 1865

8. AGE: Years	Months	Days	If less than one day
79	9	8	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Electrical Cont.
11. Industry or business

FATHER
12. Name Edward Holland
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Amanda Stewart
15. Birthplace Baltimore Md

16 (a) Informant Mrs Mary N. Holland
(b) Address 2605 Halcyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director L. J. Rough
(b) Address 5305 Harford Rd

19 (a) (Date received by Registrar) Huntington Williams Registrar

AUG 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to Aug 26 1945, and that I last saw him alive on Aug 26 1945.

Immediate cause of death	Duration
Cerebral Arteriosclerosis.	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions Dyspnea of feet to hands. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

M.D. Signature Thomas Brennan
Address 5217 Harford Road signed 8-28-45

Dr. Blake
Med. Arts. Bldg.

G31972

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G31972
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Clifton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Clifton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Denmead Roche

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	wodowed

6 (b) Name of husband or wife John Roche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Adam Broadbent
13. Birthplace Md.

MOTHER
14. Maiden Name Jane Denmead
15. Birthplace Md.

16 (a) Informant Mr. Patrick J. Roche
(b) Address 2700 Southern Avenue

17 (a) Burial (b) Date thereof 8/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (b)
(Date rec'd by Registrar) AUG 30 1945 Number Registrar's Office

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29th, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to Aug. 29 1945, and that I last saw deceased alive on Aug 28 1945.

Immediate cause of death	Duration
Due to Cer-Myocarditis.	2 yrs
Due to Diabetes.	4 yrs
Other Conditions old age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. C. Blake, M.D.
Address 1001 Cathedral Bldg. Date signed 8/30/45

G31973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G31973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 E. University Pky.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 E. University Pky.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha W. Dunnington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank P. Dunnington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1886

8. AGE: Years	Months	Days	If less than one day
59	7	25	hr. min.

9. Birthplace White Hall Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Thomas Elliott
13. Birthplace White Hall Md.

MOTHER
14. Maiden Name Sallie Wilson
15. Birthplace Sunnybrook Md.

16 (a) Informant Mr. Frank P. Dunnington
(b) Address 308 E. University Pky.

17 (a) Burial (b) Date thereof 8/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

19 (a) AUG 1 1945 (b)
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/45 19 45 at 5:15 p.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 19 45 to Aug 29 19 45, and that I last saw h.r alive on Aug 28 19 45

Immediate cause of death
Exhaustion, Toxaemia Etc.
Due to Cancer of ovaries
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
9 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed H Hayward M. D.
115 S. Eager St Date signed 8/30/45

VS 150

G31974

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G31974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 M.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A A Co
(c) City or town Lutherville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Greenwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lindy May Bell
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Wm S. Bell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 26 1875
8. AGE: Years 70 Months 6 Days 2 If less than one day hr. min.
9. Birthplace Md. Kent Co.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name James H. Meeking
13. Birthplace Kent Co. Md
MOTHER Maiden name Martha Jane Martin
15. Birthplace Md Delaware
16 (a) Informant Myrtle Brohawn
(b) Address 501 Greenwood Rd
17 (a) Burial (b) Date thereof Sept 1-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balt Co. B. M. Walker
18 (a) Funeral director Pratt & Strickler sts
(b) Address
AUG 30 1945 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945 at 9 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945 to Aug 28 1945 and that I last saw h[illegible] alive on Aug 28 1945.

Immediate cause of death — Duration
Diabetes Mellitus — 5 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Dudley Phillips M.D.
Address Piedmont Trust Bldg Date signed 8/28/45

Funeral to be held at Mt. Wilson Lane Presbyterian Church
Supplied: Joseph Shelton, M.D. 1st Lt. M.C. U.S.A.

VS 100

G31975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182

G31975

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland 17
(c) Hospital or Institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 E Eting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo D. Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife 12-14-1931

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/14/1931

8. AGE: Years 13 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation School-boy

11. Industry or business

FATHER 12. Name Albert Bradford
13. Birthplace Md.

MOTHER 14. Maiden Name Louise Beale
15. Birthplace Md.

16 (a) Informant Louise Bradford
(b) Address 1107 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Gallion & Jackson
(b) Address 916 Pennsylvania ave

19 (a) AUG 30 1945 Registrar
Thurlington for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945, at 4:45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-30-45 3:30 P. M. 25/4
(b) Where did injury occur? Chesapeake Avenue near Fourth St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Drowning.

23. Signature Howard J. Merrill M.D.
Medical Examiner.
Date signed August 30, 1945.

G31976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G31976 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 Bank Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Bank Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josephine Zawol (Cierzniak)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Walenty Zawol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1875

8. AGE: Years	Months	Days	If less than one day: hr.	min.
86	5	9	18	65

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Swideraki
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Smolinski
15. Birthplace Poland

16 (a) Informant Mrs. Helen Kulas
(b) Address 2034 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 1 45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b)

AUG 30 1945 Registrar
Huntington-Williamsville, Md.

VS 150

MEDICAL CERTIFICATION 1.30

20. DATE OF DEATH Aug. 28 1945, at AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to Aug 28 1945, and that I last saw h[illegible] alive on Aug 27 19 45

Immediate cause of death
acute gastroenteritis & dehydration and shock
Due to Diabetes mellitus
Due to (Fracture of left femur. June 30th 45

Duration
2 days
15 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-30-45 6 P. M
(c) Where did injury occur? In front of 2034 Bank St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No. (Specify type of place)
(e) Means of injury Slipped & fell from curb to street

23. Signature George D. Lilofsky M. D.
Address 4211 Pattenson Ave Date signed 8/28/45

Howard J. Moreau, M.D. X

M. D. B. 1200-9

G31977 — HEALTH DEPARTMENT—CITY OF BALTIMORE — G31977

CERTIFICATE OF DEATH √159

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 1229 McCulloh St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Herbert Roosevelt Simon

(a) Residence: No. 1229 McCulloh St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) Aug. 29, 1945

7. AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME William Simon

14. BIRTHPLACE (city or town) (State or country) Annapolis, Md.

MOTHER

15. MAIDEN NAME Lena Allen

16. BIRTHPLACE (city or town) (State or country) King George Co, Va.

17. INFORMANT Lena Simon
(Address) 1229 McCulloh St

18. BURIAL, CREMATION, OR REMOVAL
Place UNIVERSITY MEDICAL SCHOOL AUG 30 1945, 19

19. UNDERTAKER Commissioner of Health
(Address)

20. AUG 20 1945 [illegible] Williams M.D.
Registrar

2930

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 29, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1945 to Aug 29, 1945

I last saw h[illegible] alive on Aug 29, 1945. Death is said to have occurred on the date stated above, at 3:47 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Premature Birth (28 wks)	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) W. D. Bando M. D.

(Address) 2445 Dill Ave., Balto. 17

V. S. 3

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G31978 479.383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany.
(c) City or town Cumberland. (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elaine Pantleton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1-27.

8. AGE: Years	Months	Days	If less than one day
18	6	28	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alfred Pantleton
13. Birthplace Geng.

MOTHER
14. Maiden Name Iona Hand.
15. Birthplace md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/45 (month) (day) (year)
(c) Cemetery or crematory Fill Crypt Army.
Location Cumberland, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) Date received by registrar 8 Nov 1945 (b) Signature for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 29 - 1945 at 11.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 27 - 1945 to Aug - 29 1945 and that I last saw h[illegible] alive on Aug - 29 1945.

Immediate cause of death Respiratory failure — Duration 3 days
Due to Brain Tumor
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Young M. D.
Address Johns Hopkins Hospital Date signed 8-30-45

X

G31979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31979 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 Arlington Ave.
(c) Hospital or institution: Boarding

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 N Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Oliver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Robt Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/1874

8. AGE: Years	Months	Days	If less than one day
71		4	hr. min.

9. Birthplace Danville Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Beatrice Dupree
(b) Address 912 Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Memorial Park
Location Baltimore Co Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Aug 30 1945
(Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945 at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1945 to Aug 27-1945, and that I last saw h[illegible] alive on 8-27-1945.

Immediate cause of death	Duration
Chronic Cardio Vascular Renal disease	1 yr.
Due to Intestinal Bowels perforation	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jackson M. D.
Address 600 Arlington Ave signed

VS 150

631980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. 631980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Kennedy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norton R. Bechtel

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-4897

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) July 8 1881

8. AGE: Years	Months	Days	If less than one day
64	1	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Masonic Bldg

FATHER
12. Name James S. Bechtel
13. Birthplace Pa.

MOTHER
14. Maiden Name Annie M. Holmes
15. Birthplace Balto. Md.

16 (a) Informant Nellie Nickel
(b) Address 2812 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
Address 17 St. Paul St.

19 (a) (Date rec'd by registrar) AUG 31 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1945 at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 19 to 8/28 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Pulmonary edema	
Due to Carcinomatosis	
Due to Ca of liver & gall bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinomatosis; pulm. edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. R. Steinbach M.D.
Address Sinai Hosp. Date signed 8/29/45

VS 150

TAINTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31981

124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Co.
(c) City or town Woodbrook
(If outside city or town limits, write RURAL and give town)
(d) Street No. Meadow Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton Orlyn Tainton

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marianne Tainton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-1891

8. AGE: Years 54 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace South Africa
(Town, county, and state)

10. Usual Occupation
11. Industry or business Meteorologist

FATHER
12. Name Clifton Lamar Tainton
13. Birthplace South Africa

MOTHER
14. Maiden Name Florence Hale
15. Birthplace South Africa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) AUG 31 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30 1945 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 1945 to 8-30 1945 and that I last saw h[illegible] alive on 8-30 1945

Immediate cause of death	Duration
Cachexia	
Anemia	
Due to Cirrhosis of The	1 yr
Due to Liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Richardson M.D.
Address Johns Hopkins Date signed 8/30/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G31982 MihM ✓ G31982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline Ave. 24

(c) Hospital or institution: St. Joseph's Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1410 Riverside Ave North Charles St. (If outside city limits, give locality)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Andrew H. Jackson

3 (b) If veteran, name war W

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 63 Months 5 Days 22 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Catholic Church

FATHER 12. Name Henry C Mihm

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Walburga (Barbara) Handel

15. Birthplace Bath Md

16 (a) Informant Geo. C. Mihm

(b) Address Washington D C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day), (year)

(c) Cemetery or crematory Mt Olivet

Location Washington D C

18 (a) Funeral director Gillbon Co Inc

(b) Address 1217 St Paul

19 AUG 31 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30/45 19 , at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28/45 19 , to 8/30/45 19 , and that I last saw him alive on 8/30/45 .

Immediate cause of death	Duration
Cerebro-vascular accident.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. A. Rodgers M. D.

Address St. Joseph's Hosp Date signed 8/30/45

VS 150

G31983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G31983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution Lying Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 N. Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 13 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY AUG 29 1945

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 31 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/45 19 at 5:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.

Date signed 8/14/45

G31984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G31984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 N. BELNORD AVE.
(c) Hospital or institution:

6-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. BELNORD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELIZABETH WARD

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced.: WIDOW

6 (b) Name of husband or wife: EDWARD WARD

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 1 1866

8. AGE: Years 79 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name PATRICK DUFFY
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY GREEN
15. Birthplace IRELAND

16 (a) Informant EDWARD J. WARD (SON)
(b) Address 211 N. BELNORD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 1/45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location HARFORD ROAD

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. WOLFE ST.

19 AUG 31 1945 (b) Registrar Huntington Holtzman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 29 1945, at 10/15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12th 1945 to Aug 22 1945 and that I last saw h— alive on 8/22-3 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 11 days

Due to: Cardio Vascular Disease — 2

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Jaulon M. D.
Address 100 N. Mulberry Date signed 8/31/45

X

VS 150

631985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46c

Registered 631985

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 S.EAST AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-11
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S.EAST AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA J.ZEBERLEIN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife: CASPER ZEBERLEIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT.20 1886

8. AGE: Years	Months	Days	If less than one day
58	10	9	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name WILLIAM BOSLEY
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name REBECCA J.BAKER
15. Birthplace BALTO.MD.

16 (a) Informant LAWRENCE J.NASH (SON)
(b) Address 719 S.EAST AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT.3/45 (month) (day) (year)
(c) Cemetery or crematory DEER PARK
Location REISTERSTOWN MD.

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S.WOLFE ST.

19 (a) AUG 31 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG.29 1945 at 10/15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1945 to Aug.29 1945, and that I last saw her alive on Aug.29 1945

Immediate cause of death	Duration
Cancer of Duodenum	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J.A. Rosenblatt M. D.
Address 3018 O'Donnell St Date signed 8-31-45

VS 150

Huntington Williams, M.D.

X

631986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 32159

631986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo. 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Spruce Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Charles Grady

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 578-18-2857

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	9	hr. min.

9. Birthplace Boston, Massachusetts (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Seafaring

FATHER
12. Name Charles P. Grady
13. Birthplace Quincy, Massachusetts

MOTHER
14. Maiden Name Ella Sticklen
15. Birthplace Wellsbourough, Pa.

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Baltimore, Maryland

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 31/45 (month) (day) (year)
(c) Cemetery or crematory ST. JOHNS CEM.
Location ELLICOTT CITY MD.

18 (a) Funeral director Talbert & Zeale
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) (b) AUG 31 1945 Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 28 1945, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1945 to Aug. 28 1945, and that I last saw him alive on Aug 28 1945.

Immediate cause of death	Duration
Endocarditis, Bacterial, Subacute.	Several months
Pneumonia, Lobar, Lower Lobes,	
Due to Bilateral.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.

Address U. S. Marine Hospital Date signed 8/30 45

VS 180

X

G31987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G31987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Lemmon St (Lemmon St)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Lemmon St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rufus Bond

3 (b) If veteran, name war No | (c) Social Security Account No. 219-14-1479

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10-1910

8. AGE: Years	Months	Days	If less than one day
35	6	19	hr. min.

9. Birthplace Windsor, N.C. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business Continental Oil Co

FATHER
12. Name Thos Bond
13. Birthplace N.C.

MOTHER
14. Maiden Name Eva. Parker.
15. Birthplace N.C.

16 (a) Informant John Bond
(b) Address 1520 Brady ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James Adams
(b) Address 142 W. Fitch St
AUG 31 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION 12 30 P.

19. DATE OF DEATH Aug 29 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1945, to Aug 29 1945, and that I last saw he alive on Aug 29 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. William Frey, M.D.
Address 1928 Penna Ave Date signed 9/30/45

VS 150

X

G31988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 937

G31988
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2419 N. Pulaski St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½-4
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and name town)
(d) Street No. 2419 N. Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Levin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	Widowed

6 (b) Name of husband or wife Evelyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE Years	Months	Days	If less than one day
92			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Minda
15. Birthplace Russia

16 (a) Informant Mrs Nathan Glueckman
(b) Address 2419 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Rd + Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29- 1945 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1945 to 8-29 1945 and that I last saw h alive on 8-29 1945

Immediate cause of death Hypertensive C-V-D & Congestive Heart Failure — Duration 3 mos

Due to None

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Ashman M. D.
Address 1201 Eutaw Place St Date signed 8/30/45

Edward J. Clemens, M.D.

G31989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G31989 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2853 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Laker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years: 82 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Joshua Laker
(b) Address Argyle & Hoffman St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-31-45 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Germaw Stall Road

18 (a) Funeral director Jos. H. Levy Inc
(b) Address 409 E Balto St

19 (a) (Date received by registrar) (b) Registrar
AUG 31 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1945 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1928 to 8/30-1945 and that I last saw her alive on 8/30-1945.

Immediate cause of death: acute myocardial insufficiency — Duration: one week

Due to: Pernicious Anemia — Duration: about 15-20 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Herman Seidel

Address 2404 Eutaw Pl Date signed 8/30/45 (M. D.)

X

631990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1100 B

631990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1½
(e) Length of stay in Baltimore (yrs., mos., or days): 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Balto (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3607 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: LENA SAVAGE

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace: New York City (town, county, and state)

10. Usual Occupation: Home wife

11. Industry or business:

FATHER
12. Name: Abraham Cohen
13. Birthplace: Russia

MOTHER
14. Maiden Name: Ella
15. Birthplace: Russia

16 (a) Informant: Husband
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-31-45 (month) (day) (year)
(c) Cemetery or crematory: Brai Israel
Location: Baltimore Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1439 E. Baltimore St

19 (a) (Date received by registrar) (b) (Registrar)

NOV 21 1945 Huntington Hospital, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/30 1945 at 6:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8/30 1945.
and that I last saw her alive on 8/30 1945.

Immediate cause of death: Cardiac failure — Duration:
Due to: pulmonary infarction
Due to: femoral phlebo-thrombosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Daniel Hamburger M. D.
Address: Sinai Hospital Date signed: 8/30/45

X

G31991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G31991

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Webb Jackson Diggs
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Robert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 5 1885
8. AGE: Years 60 | Months 11 | Days 13 | If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Fox
13. Birthplace Caroline Co. Va

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Lillian D Jefferson
(b) Address 914 N. Bond St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A A County Md
18 (a) Funeral director Mrs. Robert J. Ellis Jr
(b) Address 1129 N. Carlton St.
19 (a) (Date rec'd by reg.) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28- 1945 at 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1945 to 8-28- 1945
and that I last saw h[illegible] alive on 8-28- 1945

Immediate cause of death	Duration
Uremia & Arteri Sclerosis	1 day
Due to Nephro Sclerosis	2
Due to Arteriosclerosis	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lowe E Hamm M. D.
Address 2340 Madison Ave Date signed 8-30-45

150

G31990 G31992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 131B

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1447 Decatur St., ... Ward)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME John Doe

If U. S. Veteran specify WAR .....

(a) Residence: No. 1447 Decatur St., 24-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed or divorced: HUSBAND of (or) WIFE of Ludwika

6. DATE OF BIRTH (month, day, year) June 24/1873

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	2	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. B & O R.R. Co

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Marek Doe

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Anna

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Laura Lemans
(Address) 1447 Decatur St.

18. BURIAL, CREMATION, OR REMOVAL
Place Holy Rosary Date Sept 1 1945

19. UNDERTAKER Fred W Ozarowski
(Address) 1930 Eastern Ave

20. FILED Huntington Williams Registrar.
AUG 31 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 24, 1945

22. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1945 to Aug 24, 1945

I last saw him alive on Aug 23, 1945 Death is said to have occurred on the date stated above, at 1:45 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocardial Degeneration	1941
Other contributory causes of importance: Chronic Nephritis	1941

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
..... If so, specify .....

(Signed) M. Kallod M. D.

(Address) 207 E. Fort Ave

X

631993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

631993

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution: East Baltimore Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9

(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3012 Clifton Avenue (If rural, give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rudolph J. Herold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth Herold

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1866

8. AGE: Years 79 | Months 5 | Days 25 | If less than one day 26 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired Sculptor

11. Industry or business

FATHER 12. Name Frederick Herold

13. Birthplace Germany

MOTHER 14. Maiden Name Maria Schmidt

15. Birthplace France

16 (a) Informant Mrs. Elizabeth Herold

(b) Address 3017 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore, Md.

18 (a) Funeral director H. Howard Strong

(b) Address 3207 N. North Ave.

19 (a) (b) Huntington Williams, M.D.

(Date rec'd by registrar) 631993

Vs 151

MEDICAL CERTIFICATION — 1A.

20. DATE OF DEATH August 30, 45, 19, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-31-45 at 12:15 A. M.

(b) Where did injury occur? North Ave. 30 feet west of Rosedale Street

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.

(d) Means of injury Pedestrian struck by Auto.

23. Signature Robert L. Forstein M.D. Medical Examiner.

Date signed August 30, 1945.

X

G3199 G31994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 Druid Park Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Druid Park Drive (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Grace Myrtle Harden

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Female
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William C. Harden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1885

8. AGE: Years 60 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Robert M. Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah F. Boyer
15. Birthplace Maryland

16 (a) Informant William C. Harden
(b) Address 2103 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Filed AUG 31 1945 (b) Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29- 1945, at 5-25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1941; to Aug 29th 1945.
and that I last saw h[illegible] alive on August 1945.

Immediate cause of death Cerebral hemorrhage — Duration 6 mo
of six days duration.
Due to Arteriosclerosis — about
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. A. Lerch M. D.
Address 3640 [illegible] Date signed 8/30/45

X

G31995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 157E

G31995

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address John street & Lafayette Ave.

(c) Hospital or institution: Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. John street & Lafayette ave. (If rural give location)

3402 E Lesley Ave

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Bostman

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/45

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation new born

11. Industry or business

FATHER

12. Name Frank J. Bostman

13. Birthplace Baltimore Maryland

MOTHER

14. Maiden Name Elsie E. Metzger

15. Birthplace Baltimore Maryland

16 (a) Informant Hospital Records

(b) Address John street & Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home

(b) Address 7411 Belair Rd.

AUG 31 1945

Registrar

Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1945 to 8/30 1945

and that I last saw him alive on 8/30 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Congenital Anomalous heart.	Birth
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Congenital Anomalous Heart

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Victor A. Neiss M.D.

Address Hospital for Women of Maryland

Date signed 8/31/45 M. D.

X

G31996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G31996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town ~~this~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 148 S. Morley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George O. Moxley

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1943

8. AGE: Years	Months	Days	If less than one day
2	3	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Albert Moxley
13. Birthplace Mt. Airy, Md.

MOTHER
14. Maiden Name Mildred Altemus
15. Birthplace Balto., Md.

16 (a) Informant Mr. Albert P. Moxley
(b) Address 148 S. Morley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1945 to 8/30 1945, and that I last saw h alive on 8/30 1945

Immediate cause of death	Duration
Primary Shock	
Due to Strangulated ventral hernia	20 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Asbury Selbourden M.D.
Address St Agnes Hosp. Date signed 8/30/45

Supplemental: Chester J. Lubinski M.D. per Resident Physician M.D. X

G31997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

Registered No. G31997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cleveland & Cayuga
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

G30041

3 (a) FULL NAME Eleanor B. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Alston O. Myers
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1917

8. AGE: Years	Months	Days	If less than one day: hr.	min.
27	8			

9. Birthplace Del. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph M. Flaherty
13. Birthplace Md.

MOTHER
14. Maiden Name Isabelle Flynn
15. Birthplace Del.

16 (a) Informant Alston O. Myers
(b) Address 1950 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Lahey & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945 to Aug 30 1945 and that I last saw h[illegible] alive on Aug 30 1945

Duration

Immediate cause of death Respiratory failure
Due to Uremia, Acute cardiac failure, Pulmonary edema
Due to Acute Glomerulitis nephritis - Pregnancy
Other Conditions Termination 8/7/45 (Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Baetjer M. D.
Address West Baltimore General Hospital Signed 8/30/45

X

G31995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31998
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael [illegible] Howe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1870

8. AGE: Years	Months	Days	If less than one day
75	4	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Assistant Wrecker

11. Industry or business

FATHER
12. Name John Howe
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Hannigan
15. Birthplace Ireland

16 (a) Informant Mrs. James McMillan
(b) Address Bayside Long Island N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)

(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave. Huntington for Williams

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1945, at 5 50 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gas Gangrene
R leg Amputation
L left leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 27/18 50
(a) Date of injury August 28 1945 12 A.M.
(b) Where did injury occur? 57 Clarke Ave & Belvedere Roads
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Pedestrian struck by street car

23. Signature [illegible] M.D.
Medical Examiner.
Date signed Aug 28 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31999

478472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 M

G31999 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot.
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 South St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth Sigman Newell.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-45

8. AGE: Years	Months	Days	If less than one day
	5	27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Roy S. Newell
13. Birthplace Del.

MOTHER 14. Maiden Name Frances Russ
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3/45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director C. Ellis Clark
(b) Address Easton, Md.

19 (a) AUG 31 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug. 31 1945, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1945 to Aug. 31 1945, and that I last saw him alive on Aug. 31 1945.

Immediate cause of death Respiratory failure — Duration

Due to Aspiration of mucus & vomitus

Due to Amyotonia Congenita

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Everett, M.D. Assistant Resident
Address Johns Hopkins Hospital Date signed 8/31/45

VS 150

632000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 632000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 W Lanvale St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 W Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F. | 5. Color or race Cd | 6 (a) Single, married, widowed, or divorced. Wid

6 (b) Name of husband or wife David

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/31/87

8. AGE: Years 57 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Fla (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Meehler

13. Birthplace Fla

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant David A. Johnson

(b) Address 1705 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/41 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director Wm. H. Nelson

(b) Address 4394 Pressman St

19 (a) AUG 31 1941 (Date rec'd by registrar) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1941 at 4. P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 3 1941 to Aug 25 1941 and that I last saw h[illegible] alive on August 25th 41.

Immediate cause of death Chronic Cardio Vascular Renal Disease — Duration 1 yr

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P Graham M. D.

Address 600 N Arlington Date signed 8-30-41

VS 150

32001

HEP #95449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49D

Registered No. G32001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Otterbein St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Ragaler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1892

8. AGE: Years 53 | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Ragler
FATHER 13. Birthplace ? ? Md

MOTHER 14. Maiden Name Henrietta Ragler
MOTHER 15. Birthplace ? ? Md

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-45 (month) (day) (year)
(c) Cemetery or crematory H.H. Stephens Mg
Location Elkridge

18 (a) Funeral director H. Hughes Johnson
(b) Address Ellicott City Md

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14, 1945, to Aug. 30, 1945, and that I last saw her alive on Aug. 30, 1945

Immediate cause of death	Duration
Carcinoma of vulva Primary	
Due to	
Due to	
Other Conditions Pregnancy, ascites (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
Autopsy? Portal Hypertension
Of autopsy Carcinomia of Vulva-Metastasis to Liver

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B-H Date signed 8/31/45

VS 150

G32002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G32002 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or Institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John B. Gilmore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29, 1909

8. AGE: Years	Months	Days	If less than one day
35 36	9	-	hr. min.

9. Birthplace Norfolk, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Columbus Gilmore
13. Birthplace Charlotte Co.

MOTHER
14. Maiden Name Essie Watkins
15. Birthplace Carthage, N.C.

16 (a) Informant Essie Gilmore
(b) Address 1122 McCulloh Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-1945 (month) (day) (year)
(c) Cemetery or crematory ~~Mt. Auburn~~ ~~Cemetery~~
Location ~~Baltimore~~ A. Halstead

18 (a) Funeral director 911 Send Welfare.
(b) Address

AUG 31 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1945, at 8:00 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mesmer M.D. Medical Examiner.
Date signed 8-29-45.

VS 151

X

G32003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G32003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Penna. ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille Washington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Winnsboro, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Fanster
13. Birthplace S.C.

MOTHER
14. Maiden Name Jannie
15. Birthplace S.C

16 (a) Informant Lucille Washington
(b) Address 1317 Penna. ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (month) (day) (year)
(c) Cemetery or crematory
Location Winnsboro, S.C.

18 (a) Funeral director Elvay O. Wilson
(b) Address 1300 Brantley ave

AUG 31 1945
(Date rec'd by registrar) Huntington Williams M.D.

8/29/45

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 16 1944, to Aug 29 1945, and that I last saw him alive on Aug 28 1945.

Immediate cause of death	Duration
Aortic Incompetency (Chronic Valvular Disease)	2 yrs.
Due to (and) Hypertensive Cardiac disease	
Due to Cardiac Decompensation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas Julian Jr. M.D.
Address 511 N. Schroeder St Date signed 8/30/45

VS 150

X

G32004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G32004

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 W. Lee St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Same (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 W. Lee St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Arthur

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	18	hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Arthur.
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Jane
15. Birthplace Calvert Co. Md.

16 (a) Informant William Arthur
(b) Address 229 N. Schroeder St

17 (a) Burial (b) Date thereof Aug. 31 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Washington Ave Williamsport, Md

19 (a) AUG 31 1945 (b) Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1945; at 5:44 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2 1945 to 8/28 1945.
and that I last saw h[illegible] alive on 8/27 1945

Immediate cause of death	Duration
(a) Uremia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben R Lutts M. D.
Address 34 Druid Hill Ave Date signed 8/29/45

G32005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BURIAL

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 S. Sharp
(c) Hospital or institution Balto md
(d) Length of stay in hospital or inst. (yrs., mos., or days) NV
(e) Length of stay in Baltimore (yrs., mos., or days) 45y

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County Balto
(c) City or town Balto md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 S Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Hicks (Boy)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife Susanna Hicks
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 29 - 1865

8. AGE: Years	Months	Days	If less than one day
80	1865	Feb 29	hr. min.

9. Birthplace Calvert Co Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name	Abraham Hick
FATHER — 13. Birthplace	Calvert Co Md
MOTHER — 14. Maiden Name	Hester Sims
MOTHER — 15. Birthplace	Calvert Co Md
16 (a) Informant	Bro. W. Jackson
(b) Address	1713 N. Dallas
17 (a) Burial, cremation, or removal	Burial
(b) Date thereof (month) (day) (year)	Sept 1, 1945
(c) Cemetery or crematory	Mt. Auburn
Location	
18 (a) Funeral director	Miss Katie R Wilkins
(b) Address	3222 Washington Blvd
19 (a) Date rec'd by registrar	AUG 31 1945
(b) Registrar	

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945, at 1030A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945 to Aug 29 1945 and that I last saw h[illegible] alive on 8-28-1945.

Immediate cause of death	Chron. Myocardial Degeneration	Duration
Due to	Cardiac Dilatation	
Due to	Chron. Gastritis Bronchitis	
Other Conditions	Scrotal Hernia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm R Boykin MD
Address 1135 Edmondson Date signed 8/31/45

VS 3

G32006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G32006

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 W Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William McKim Hayes

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M. | 5. Color or race white | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 28 1877

8. AGE: Years 66 | Months — | Days 2 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John S. Hayes
13. Birthplace Va.

MOTHER
14. Maiden Name Susan McKim
15. Birthplace Md

16 (a) Informant A Gordon Hayes
(b) Address 24 W Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W Berkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) AUG 31 1945 (Registrar's signature) Huntington Hilleary, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 29 1945, to August 30 1945, and that I last saw him alive on August 30 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage accident	2 days
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frances W. Gluck, M. D.
Address 715 Park Ave Date signed 8/31/45

VS 150

G32007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 12

G32007 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman W. Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lina E. Katz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1874

8. AGE: Years	Months	Days	If less than one day
71	2	10	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Paper Jobber
11. Industry or business

FATHER 12. Name Louis Katz
13. Birthplace Germany

MOTHER 14. Maiden name Sophie Wallbach,
15. Birthplace Germany

16 (a) Informant Paulina E. Katz
(b) Address 2111 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/45.
(month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Forest Park, Md.

18 (a) Funeral director Samuel Sonneborn & Son
(b) Address 120 E. Lexington St. Baltimore, Md.

19 (a) AUG 31 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1945 at 1 1. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1945 to Aug. 31, 1945 and that I last saw him alive on Aug. 31, 1945.

Immediate cause of death	Cardiac failure	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss, M.D.
Address Sinai Hospital Date signed 8/31/45

VS 150

G32008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G32008

JO #92366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 29 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 743 McHenry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lewis Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1916

8. AGE: Years	Months	Days	If less than one day
28	11	29	hr. min.

9. Birthplace Virginia (Linden, Warren County) (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Restaurant

FATHER

12. Name Edgar Thompson (d)

13. Birthplace Virginia (Howellsville)

MOTHER

14. Maiden Name Ellen Gardner

15. Birthplace Maryland (Cross Keys)

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location Front Royal, Virginia

18 (a) Funeral director M. F. Sedwick & Sons

(b) Address 1808 Eastern Ave

19 (a) Date received AUG 31 1945 (b) Registrar Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 2:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1945, to Aug. 30, 1945, and that I last saw h. im alive on Aug. 29, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	5
Miliary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Hubert B. Copeland Jr. M.D.

Address Balto. City Hosp. Date signed 8/30/45

VS 150

632009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 632009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 W. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Lorretta Nugent

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-03-2078

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1918

8. AGE: Years 26 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Inspectress

11. Industry or business Bendix (Factory)

FATHER
12. Name James Joseph Nugent
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elsie M. Emig
15. Birthplace Balto. Md.

16 (a) Informant Mr. & Mrs. James Nugent
(b) Address 1112 W. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director Fred. A. Evans & Son
(b) Address 856 N. Charles St.

19 AUG 31 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29th 1945, at 7.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945 to Aug 29 1945 and that I last saw h alive on 8/29/45 1945.

Immediate cause of death — Duration

Carcinoma of uterus — 5 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 517 Scott St. Date signed 8/31/45

VS 150

632010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 632010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Hanford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Adamas.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female.	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-89.

8. AGE: Years	Months	Days	If less than one day
56.	3	10	hr. min.

9. Birthplace Rumania
(Town, county, and state)

10. Usual Occupation Home- wife

11. Industry or business

FATHER
12. Name Theodor Tid
13. Birthplace Roumania.

MOTHER
14. Maiden Name Anna Montsan
15. Birthplace Roumania

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2/45 (month) (day) (year)

(c) Cemetery or crematory Erie, Pa
Location

18 (a) Funeral director John O. Mitchell & Sons Inc
(b) Address 1900 Eutaw Place, Huntington Williamsport

AUG 31 1945
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 31 - 1945 at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20. 1945 to Aug. 31 1945. and that I last saw him alive on Aug. 31 1945.

Immediate cause of death Cachexia, Uremia

Due to ? Carcinoma of Bone!

Due to

Other Conditions Cerebrospinal Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Not performed

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laura Dickson M. D.
Address Johns Hopkins Hosp Date signed 8/31

VS 150

G32011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G32011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Ridgely St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Ridgely St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche B. Gardner

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Frank Gardner
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 24, 1888

8. AGE: Years 57 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry East
13. Birthplace New York

MOTHER
14. Maiden Name Emma Jenkins
15. Birthplace Maryland

16 (a) Informant Mildred Siegel
(b) Address 1149 Ridgely St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-3-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George P. Schwab
(b) Address 2101 Frederick Ave.

19 AUG 31 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945, to Aug 30 1945, and that I last saw her alive on Aug 29 1945.

Immediate cause of death Carcinomatosis

Duration 2 mo

Due to Carcinoma of Breast operation

Duration 2 yr. 7 mo.

Due to

Other Conditions Paralysis of Lt female 8 months.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R O Adams M. D.
Address 2208 Hollins Ferry Rd. Date signed 8/31/45

VS 150

G32012 — Over — G32012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 years 3 mos. 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) home

2. USUAL RESIDENCE OF DECEASED:
(a) State R. I. (b) County
(c) City or town Manville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend Gedeon ISIDORE Lambert

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1888

8. AGE: Years	Months	Days	If less than one day
56	9	9	hr. min.

9. Birthplace Providence, R. I. (Town, county, and state)
10. Usual Occupation Priest
11. Industry or business

FATHER — 12. Name Odilon H. Lambert
13. Birthplace Canada

MOTHER — 14. Maiden Name Melina (Melania) Jalbert
15. Birthplace Canada

16 (a) Informant Mount Hope Retreat
(b) Address 640 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4/45 (month) (day) (year)
(c) Cemetery or crematory St. Anns Cemetery
Location Providence, R. I.

18 (a) Funeral director Stewart & Norman Company
(b) Address 103 W. North Ave, City

AUG 31 1945 (Date rec'd by registrar) Filed for record by Williams, M.B. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, at 8:09 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to Aug. 31 1945, and that I last saw him alive on Aug. 31 1945.

Immediate cause of death: Carcinoma of duodenum — Duration: 6 mos.
Due to
Due to
Other Conditions: General Arteriosclerosis with hypertension — 2½ years.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 33 Woodside Ave Date signed

G32013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G32013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town City of Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 E. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or Race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19 45

8. AGE: Years | Months | Days 12 | If less than one day hr. min.

9. Birthplace Balto Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Johnson
13. Birthplace Balto Md

MOTHER 14. Maiden Name Norma Ryan
15. Birthplace Balto Md

16 (a) Informant Dora Ryan
(b) Address 2513 E Fairmount Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 1-45 (month) (day) (year)
(c) Cemetary or crematory Greenmount
Location Oliver - Greenmount Ave.

18 (a) Funeral director William Bork Inc
(b) Address 1217 St Paul Street

Aug 31 1945 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1945 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to Aug 31 1945 and that I last saw her alive on Aug 31 1945

Immediate cause of death Peritonitis + purulent meningitis

Due to Following operative intervention for stenosis of small intestine (Congenital)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 28, 1945

Major findings of operation stenosis of small intestine, peritonitis + meningitis

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnall Patz M.D.
Address Sinai Hosp Baltimore, Md. Date signed 8-31-45

G32014

HEP #94800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G32014 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 13 1M-13D
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 7010 Dunbar Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Jean Carpenter

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry L. Carpenter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1915

8. AGE: Years	Months	Days	If less than one day
30	7	2	hr. min.

9. Birthplace Orville, Ala. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name W. E. Rollins
13. Birthplace Tenn.

MOTHER
14. Maiden Name Bevla Lee
15. Birthplace Ala.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 4/1/45 (month) (day) (year)
(c) Cemetery or crematory Selma
Location Selma, Alabama
18 (a) Funeral director Williams Funeral Home
(b) Address 1292 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1945, at 2:05P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1945, to Aug. 30, 1945, and that I last saw her alive on Aug. 30, 1945

Immediate cause of death	Duration
Carcinoma of breast with metastasis	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 5-16-45
Major findings of operation: Pathological fracture of L. hip
of autopsy: At above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps. Date signed 8-30-45

G32015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32015 Registered No. 108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Orems Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Dell Fay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 15 - 1945

8. AGE: Years	Months	Days	If less than one day
	2	15	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. Fay
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ellen Kauppinen
15. Birthplace New Hampshire

16 (a) Informant Mrs. Ellen Fay (mother)
(b) Address 1217 Orems Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John D Connelly
(b) Address 48 Eastern Ave. Balto. 21

19 (a) (Date rec'd by reg.) (b) Livingston Williams, Registrar

AUG 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1945, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1945 to 8-29 1945 and that I last saw her alive on 8-29 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Tracheo-Bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. Das Pendergrass

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 8-29-45

303 G32016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G32016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills -
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Thomas -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-44

8. AGE: Years	Months	Days	If less than one day
	9	25	hr. min.

9. Birthplace Md -
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Henry Willis
13. Birthplace —

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Md -

16 (a) Informant Friends -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 1 46 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Cabert Co

18 (a) Funeral director C. E. Lewis
(b) Address Prince Frederick Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945 at 1 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28, 1945 to Aug 30 1945 and that I last saw h alive on Aug 30 1945.

Immediate cause of death Respiratory failure

Due to ? Miliary tuberculosis

Due to

Other Conditions Diarrhea, duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Bateson M. D.
Address Johns Hopkins Hospital Date signed 9/21/45

Assistant Resident

VS 150

G32017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G32017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Howard
(c) Hospital or institution: Med Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 "
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Rural - Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose B. Barber

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John W. Barber

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1879

8. AGE: Years 65 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Levi Harris
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Adaline Appler
15. Birthplace: Maryland

16 (a) Informant: John W. Barber
(b) Address: Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-45 (month) (day) (year)
(c) Cemetery or crematory: Meadow Branch
Location: near Westminster. Carroll Co. Md

18 (a) Funeral director: C. M. Waltz
(b) Address: Winfield, Md.

19 (a) Filed SEP 1 1945 (b) Registrar: Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1945, at 1 25 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry: D + D thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hir death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Shock

Due to: 1° + 2° burns over entire body

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug 31st at M.
(b) Where did injury occur? Westminster Md
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? Yes
(d) Means of injury: Gasoline Explosion

23. Signature: Joseph L. Shuham M.D. Medical Examiner.
Date signed 9/3/45

G32018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G32018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully typed. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Leonardtown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Mary Greenwell

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-06

8. AGE: Years 39 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Walter Norris
13. Birthplace Md

MOTHER 14. Maiden Name Emma Brailey
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3 1945 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Hollywood, Md

18 (a) Funeral director M.C. Mattingley Sons
(b) Address Leonardtown, Md

19 (a) SEP 1 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1945 to Aug 31 1945 and that I last saw h[illegible] alive on Aug 31 1945.

Immediate cause of death Ruptured appendix Intestinal obstruction

Due to Ruptured appendix

Due to

Other Conditions Pregnancy

(Include pregnancy within 3 months of death)

Date of operation 8-30-45

Major findings of operation: appendicitis & Obstructing band.

of autopsy:

PHYSICIAN Give cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Mueller M.D.
Address The Johns Hopkins Hosp. Date signed 8-31-45

VS 150

632019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 632019

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 231 N. Fulton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) 65 years Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 231 N. Fulton Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Gallagher

3 (b) If veteran, name war: W

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel O Gallagher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8. 1885

8. AGE: Years 59 | Months 9 | Days 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER

12. Name William O Byrne

13. Birthplace Ireland

MOTHER

14. Maiden Name Anna Mussoy

15. Birthplace Ireland

16 (a) Informant Louise A Murphy

(b) Address 2718 E Hamilton St Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cathedral

Location Baltimore Md

18 (a) Funeral director Tillman & Son Inc

(b) Address 2140 E Pratt St

SEP 1 - 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1945 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to Aug. 31 1945 and that I last saw HER alive on Aug 31 1945

	Duration
Immediate cause of death: Terminal pneumonia	8 days
Due to: Arterio sclerosis Myocarditis	2 years
Due to:	
Other Conditions: Varicose ulcers	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature Barclay Bryant M. D.

Address 3812 Greenmount ave. Date signed Aug 31 45

G32020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G32020 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1471 Woodall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1471 Woodall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence C. George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17 - 1892

8. AGE: Years	Months	Days	If less than one day
52	11	14	hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Chauffer
11. Industry or business

FATHER
12. Name John George
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ida M. Chaffman
15. Birthplace Baltimore Md

16 (a) Informant Ida M. George
(b) Address 1471 Woodall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flannery
(b) Address 142 Light St.

19 (a) SEP 1 - 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1945, at 12:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1945, to 8-31 1945, and that I last saw him alive on 8-31 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Talbot M. D.
Address 707 E. Fort Ave. Date signed 8-31-45

VS 150

X

G32021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G32021

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 534 E. Clement St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 E. Clement St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida M. Hauck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William A. Hauck

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept. 2- 1889

8. AGE: Years 56 | Months 11 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housework

FATHER
12. Name Thomas J. Conroy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Amelia Boarnitz
15. Birthplace Germany

16 (a) Informant Louis Scully
(b) Address 140 E. Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flippo & Flanning
(b) Address 1476 Light St.

19 (a) (b) Huntington Williams, M.D.

SEP 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1945, at 10:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942, to Aug. 30 1945, and that I last saw her alive on Aug. 30, 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Friedman M.D.

Address 1319 Light St. Date signed 9/4/45

G32022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

48 B

G32022
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S Seedbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Cordner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~ (widowed), or divorced: Widow

6 (b) Name of husband or wife: Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23 - 1869

8. AGE: Years 76. Months 6 Days 8 If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name James Gardner
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Maryland Gen. Hos.
(b) Address Linden & Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3-45 (month) (day) (year)
(c) Cemetery or crematory Levering Presbyterian
Location Belona Ave.

18 (a) Funeral director John G. Moran
(b) Address 3000 E Baltimore St

19 (a) (b) Registrar
~~Filed~~ Rec'd by registrar SEP 1 - 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1945 at 11 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to Aug 31 1945 and that I last saw her alive on Aug. 30 1945

Immediate cause of death: Terminal cachexia
Heart failure
Due to: Anaplastic Carcinoma
Due to: of Uterus
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation Aug 6/45
Major findings of operation: Opinion was a diagnostic D & C.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Juan Noguera M.D.
Address Md Gen Hosp Date signed 8-31-45

X

G32023 Dachille

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G32023 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 E. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dachisse

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Essa M.
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct 15 1887

8. AGE: Years	Months	Days	If less than one day
57	10	16	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business

FATHER 12. Name	Dominick Dachisse
13. Birthplace	Italy
MOTHER 14. Maiden Name	?
15. Birthplace	Italy

16 (a) Informant Essa M. Dachisse
(b) Address 1812 E Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory N. Cathedral
Location Frederick Ave.

18 (a) Funeral director M. W. K. Diggs & Sons
(b) Address 1900 Eutaw & Arm Sts.

19 (a) SEP 1 - 1945 (b) (Date rec'd by registrar) Huntington-Williams Mfg

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1945, at 3:50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 6 1945 to Aug. 31 1945 and that I last saw him alive on Aug 31 1945.

Immediate cause of death	Duration
Acute Cardeo-respiratory decompensation	1 day
Due to Cerebral Hemorrhage	6 yrs.
Due to	
Other Conditions Chr. Endocarditis + Myocarditis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emma Georgeo M. D.
Address 2002 E Pratt St Date signed 8/31/45

83a

G32024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G32024 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Volk

3 (b) If veteran, name war: No. | 3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1859

8. AGE: Years	Months	Days	If less than one day: hr.	min.
85	11	1		

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER	12. Name Conrad Volk
	13. Birthplace Germany
MOTHER	14. Maiden Name Dorothy Park
	15. Birthplace Germany

16 (a) Informant Pauline E Hartman
(b) Address 4 N. Lakewood Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dysard's Sons
(b) Address Lombard & Ann Sts.

(a) (Signature of registrar) Huntington Williams M.D.

SEP 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1945 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1940 to Aug. 31 1945 and that I last saw h. alive on Aug. 29 1945.

Immediate cause of death Carcinoma of rectum — Duration 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene R. Pessano M. D.
Address 514 Drury Lane Date signed Aug. 31, 1945

X

G32025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32025 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-72

8. AGE: Years 73 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Harrison Brown
13. Birthplace ?

MOTHER 14. Maiden Name Mary Brown
15. Birthplace ?

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Mrs George W Stallard
(b) Address 1831 Druid Park Lake Dr

19 (a) Date received SEP 1 1945 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945 at 7:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Aug 29 1945 and that I last saw h alive on Aug 29 1945

Immediate cause of death: Cardiac arrest
Due to Posterior myocardial infarction
Due to Hypertensive & arteriosclerotic heart disease

Duration: 4 days

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Dixon
Address Johns Hopkins Hospital 8/31/45

G32026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32026

Registered No. 1170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGAIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose L. Person
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Rosa L.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 4, 1892

8. AGE: Years	Months	Days	If less than one day
53	4	18	hr. min.

9. Birthplace Raleigh, N.C. (town, county, and state)
10. Usual Occupation Pullman Service (R.R.)
11. Industry or business

FATHER
12. Name Andrew Person
13. Birthplace Raleigh N.C.

MOTHER
14. Maiden Name Betty Davis
15. Birthplace Raleigh N.C.

16 (a) Informant Rosa L. Person
(b) Address 323 N. Calhoun St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2, 19 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. George W. Hubbard
(b) Address 1624 Druid Hill Ave.
19 SEP 1 - 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1945 at 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1945 to 8/29 1945 and that I last saw h alive on 8/28 1945

Immediate cause of death	Duration
Acute Nephritis	
Due to	
Due to	
Other Conditions Obstructing Kidney Stone (Including pregnancy within 3 months of death)	

Date of operation 8/24/45
Major findings of operation Obstructive Kidney Stone
Date of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Culpepper
Address 1131 Harlem Ave. Date signed 9/1/45

G32027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 119a

Registered No. G32027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Deborah Eggleston ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-21-45.

8. AGE: Years	Months	Days	If less than one day
	2.	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Eggleston

13. Birthplace S.C.

MOTHER 14. Maiden Name Rosa Eggleston

15. Birthplace Va.

16 (a) Informant Parents

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 / 45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location A A County Md

18 (a) Funeral director Mrs Robert A Elliott Dft

(b) Address 1129 N. Carolina Street

19 SEP 1 - 1945 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 30 - 1945 at 10.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 29 1945 to Aug - 30 1945 and that I last saw h[illegible] alive on Aug - 30 1945.

Immediate cause of death Acidosis and dehydration — Duration 4 Days

Due to diarrhea and vomiting (duration)

Due to Pertussis Pneumonia Purulent

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Everitt Bates
Assistant Resident
Address Johns Hopkins Hospital Date signed 9/3/45

X

G32028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G32028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Huron St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Huron St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CELESTINE MARTIN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife George B. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Augustus Bailey
13. Birthplace Md.

MOTHER
14. Maiden Name Christianna Cook
15. Birthplace Md.

16 (a) Informant Mrs. George B. Martin
(b) Address 2500 Huron St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) SEP 1 1945 (Date received by registrar) (b) [illegible] Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 29 1945, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945, to Aug 29 1945, and that I last saw h[illegible] alive on Aug 27 19[illegible].

Immediate cause of death	Duration
Fabroid Uterine Tumor	10 days
Due to Chronic Interstitial Nephritis	8 mos
Due to Hypertension and Influenza	1 mo.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R O Allen
Address 2708 Hallin Ave Pal Date signed 8/30/45

VS 150

G32029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100a

Registered No. G32029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkins Ave

(c) Hospital or Institution: St. Agnes Hospital 20-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 319 S Payson St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Sophia Weaver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lewis Weaver

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1879

8. AGE: Years 65 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name [illegible] Reis

13. Birthplace Balto. Md

MOTHER

14. Maiden Name Margaret Pfetzinger

15. Birthplace Balto. Md

16 (a) Informant Lewis Weaver

(b) Address 319 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (Month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Avenue

19 (a) SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945 to 8/31 1945

and that I last saw h[illegible] alive on 8/31 1945

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Overwhelming Septicemia	
Due to Infected Right Varicosity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] S. Gaw Jr

Address St Agnes Hosp Date signed 8/31/45

X

VS 150

G32030

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G32030
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Stafford St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Dena Rachel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-1858

8. AGE: Years 87 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Conrad Kapsamer

13. Birthplace Germany

MOTHER 14. Maiden Name Not Available

15. Birthplace Germany

16 (a) Informant Geo Trefts

(b) Address 6411 Hillen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-45 (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Rand Mt

18 (a) Funeral director Geo A Foley

(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 1 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945 at 2:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1945 to 8/31 1945 and that I last saw her alive on 8/31 1945

Immediate cause of death Cardiac Resp failure — Duration

Due to Chronic interstitial Nephritis

Due to Cardio Vasc Disease

Other Conditions Post Infectional pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jeff Feldt M.D.

Address 3700 Eutaw Place Date signed 8/31/45

X

G32031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32031 / 1220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 E. Hoffman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John J. Rainey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma Rainey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 1868

8. AGE: Years 76 Months 9 Days 7 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and State)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Edward Rainey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Evelyn Sabatino
(b) Address 1416 N. Ellington Ave

17 (a) 9-3 45 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Burial

(c) Cemetery or crematory London Park
Location Frederick Ave.

18 (a) Funeral director John C. Miller Inc
(b) Address 243 E. Oliver St

SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30, 1945, at 6:00 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Aug. 29, 1945 to Aug. 30, 1945 and that I last saw him alive on Aug. 30, 1945

Immediate cause of death Cardiac failure — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration over

(Include pregnancy within 3 months of death)

Date of operation Aug. 29, 1945

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hospital Date signed 8/31/45 M. D.

X

632032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 632032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N. Conkling St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 N. Conkling St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William (E) Martz

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-3003

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Johanna E Martz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1874

8. AGE: Years	Months	Days	If less than one day
69	7 8	30	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Watchmaker
11. Industry or business Bethlehem Steel

FATHER
12. Name Nicholas Martz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Louise Hammers
(b) Address 813 N. Conkling St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-1945 (month) (day) (year)
Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Foley & Miller Inc
(b) Address 1417 E Oliver St

19 (a) SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1945, at 8 AM

21. I certify that I took charge of the remains described above, held an I & O Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Thornburg M.D. Medical Examiner.
Date signed 9/1/45

VS 151

G32033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. G320033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1725 N. Port Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1725 N. Port Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A. RAHLEY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Rahley

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Mar. 8, 1892

8. AGE: Years 53 | Months 5 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Parker

FATHER 13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Lydia Horst

MOTHER 15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Charles Rahley

(b) Address 1725 N. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 10 1944 to August 31 1945 and that I last saw h[illegible] alive on Aug 31 1945

Immediate cause of death	Duration
Carcinoma of Uterus.	1 Year
Due to Cachexia and Metastasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert Rosenberg M. D.

Address 2025 E. Monument St. Date signed 9/1/45

VS 150

G32034

HEP # 15616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G32034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BURNING DISSOLVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12- 4- & 6

(e) Length of stay in Baltimore (yrs., mos., or days) 74 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 107 Caton ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Vernon Bowie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Widower

6 (b) Name of husband or wife Mary (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1871

8. AGE: Years	Months	Days	If less than one day
74	?	?	hr. min.

9. Birthplace Maryland (Frederick Co.) (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Mack

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Thomas

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)

(c) Cemetery or crematory Western Star

Location Md

18 (a) Funeral director Geo. B. Kelso

(b) Address 1303 Druid Hill Ave

19 (a) Date received SEP 1 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 6:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24, 1933, to August 30 45, and that I last saw him alive on Aug. 30, 1945

Immediate cause of death: Cerebral Thrombosis

Date unknown ?

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy not done

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address B.C.H. Date signed 8/30/45

VS 150

G32035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G32035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins - Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~County~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Hinsdale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Carl E. Hillegeist

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 215-07-9183

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth H. Hillegeist
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1898

8. AGE: Years 47 | Months 7 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Real Estate

FATHER
12. Name Bernard Hillegeist
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Cathrine Geiser
15. Birthplace Germany

16 (a) Informant Wife Elizabeth H. Hillegeist
(b) Address 2913 Hinsdale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk. Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945 to 8/31 1945, and that I last saw h[illegible] alive on 8/30 1945

Immediate cause of death	Duration
Acute Circulatory Collapse	
Due to Hemo-peritoneum	
Due to Ruptured Abd. Varices	
Other Conditions Cirrhosis of Liver and Primary Carcinoma of Liver & Metastases	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugo De Carlo M.D.
Address 1 E. Lexington St. Date signed 8/31/45

VS 150

G32036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32036
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4500 Fullerton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Henry Henenberger

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-5472

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife Dorothy Stephens Henenberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1906

8. AGE: Years	Months	Days	If less than one day
38	11	25	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Lumber Clerk

11. Industry or business F. Bowie Smith Lumber Co.

FATHER
12. Name John H. Henenberger
13. Birthplace Austria

MOTHER
14. Maiden Name Pauline Pusche
15. Birthplace Hanover Germany

16 (a) Informant Mr. Gordon L. Wheeler
(b) Address 4500 Fullerton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

SEP 1 - 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8/29/45 at 4:P. M. 27/6

(b) Where did injury occur? Harford Rd - White

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Pedestrian Struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed 8/31/45

VS 151

G32037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32037 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 Beverly Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 1
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Beverly Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mollie Marcella Mullens

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William Mullens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1861

8. AGE: Years 84 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Reagor Springs Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business housewife

FATHER
12. Name John Reagor
13. Birthplace Regor Springs Texas

MOTHER
14. Maiden Name Catherine Smithaffer
15. Birthplace 3207 Alabama Rd.

16 (a) Informant Mrs. Charles S. Shaffer
(b) Address 3207 Beverly Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ 1/ 45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Cem.
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS.
(b) Address Baltimore, Maryland

SEP 1-1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/ 31/ 1945, at 7:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 31 1945 and that I last saw h[illegible] alive on Aug 30 1945

	Duration
Immediate cause of death: Arteriosclerotic Heart Disease	[illegible]
Due to: Generalized Arteriosclerosis	[illegible]
Due to:	
Other Conditions: Chronic bronchitis — (Include pregnancy within 3 months of death)	3 mos.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Dunagan M.D.
Address 4308 Harford Rd. Date signed 9/1/45

VS 150

632038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 632038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 W. Hamburg St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23rd
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 18 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrica F. Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1945

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation mont
11. Industry or business

FATHER
12. Name Arthur E. Tolson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence A. Washburn
15. Birthplace Baltimore, Md.

16 (a) Informant Arthur E. Tolson
(b) Address 18 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Dunn & Son
(b) Address 715 Light St.

SEP 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945 to Sept 1 1945
and that I last saw h[illegible]ve on Sept 1 19[illegible]

Immediate cause of death	Duration
Obstruction	2 Days
Due to Congenital Heart	3 Days
Due to Condition	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 164 Harwood Date signed 9/1/45 M D

VS 150

G32939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B

Registered No. G32039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD. STS
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 WALBROOK AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME GEORGE WILLIAM DARBY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife SARA TYLER DARBY
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) DEC. 11, 1892

8. AGE: Years	Months	Days	If less than one day
52 53	8	20	— hr. — min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation ENGINEER
11. Industry or business GENERAL ELECTRIC CO.

FATHER
12. Name WILLIAM DARBY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name CAREY MURPHY
15. Birthplace MARYLAND

16 (a) Informant WIFE
(b) Address 3511 WALBROOK AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3/45 (month) (day) (year)
(c) Cemetery or crematory Hyattstown. Md.
Location Hyattstown Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) SEP 1 1945 (Date received by Registrar) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 31 1945, at 4.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 20, 1945 to AUG. 31, 1945 and that I last saw him alive on AUG. 31, 1945.

Immediate cause of death	Duration
HEMORRHAGE	
Due to RUPTURED AORTA	
Due to CHONDROSARCOMA OF STERNUM	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation 8/31/45
Major findings of operation: ONE-HALF INCH PERFORATION OF AORTA
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) — (County) — (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 8/31/45

VS 150

X

G32040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G32040

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 S Gilmore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

1947

3 (a) FULL NAME Theresa M. Measler

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife August Measler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13-1868

8. AGE: Years	Months	Days	If less than one day
76	8	19	hr. min.

9. Birthplace Bavaria Germany (town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? — Schalk
13. Birthplace Germany

MOTHER
14. Maiden Name Kunegunda —
15. Birthplace Germany

16 (a) Informant Wm A. Measler
(b) Address 3624 Yorkway, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore City

18 (a) Funeral director Pratt & B. M. Walter
(b) Address Pratt & Fricke Sts.

19 (a) (b) Huntington Williamsport
Date rec'd by local registrar SEP 1 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1945, at 2.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1945, to Aug 30 1945, and that I last saw h alive on Aug 30 9 45.

Immediate cause of death Diabetes Mellitus — Duration

Due to Pulmonary Infarction

Due to

Other Conditions Amputation of Rt. leg

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J E Dorsey M. D.
Address University Hosp. Date signed 8-30-45

X

G32041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G32041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Tolna St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Tolna (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Gabriel Banks, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widowed

6 (b) Name of husband or wife Mary Banks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Roumania (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bethlehem Steel, Sp. Pt. Md.

FATHER
12. Name Unknown
13. Birthplace Roumania

MOTHER
14. Maiden Name Unknown
15. Birthplace Roumania

16 (a) Informant Gabriel Banks, Jr.
(b) Address 2756 E. 4th St. Sp. Pt. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Glendale Ave.

18 (a) Funeral director John J. Connelly
(b) Address Eastern Ave. East Huntington Ave. Williams Mgr.

SEP 2 1945

19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1945 to Aug 30 1945 and that I last saw him alive on Aug 30, 1945.

Immediate cause of death	Duration
Carcinoma of Stomach	several years
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature John J. Kreger M. D.
Address 2677 Eastern Ave. Date signed

V8 180

x Kreger

G32042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32042 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Trinity St.
(c) Hospital or institution: Res.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Preston Co.
(c) City or town Kingwood (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victor W. Ringer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Rachel
6 (c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Dec. 28-1872
8. AGE: Years 73 | Months 10 | Days 4 | If less than one day ____ hr. ____ min.
9. Birthplace Preston Co. W. Va. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name William C. Ringer
13. Birthplace Preston Co. W. Va.

MOTHER
14. Maiden Name Mary Ann Smith
15. Birthplace Preston Co. W. Va.

16 (a) Informant Hallie Pobery
(b) Address 906 Trinity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4-1945 (month) (day) (year)
(c) Cemetery or crematory Centinary
Location Preston Co. W. Va.

18 (a) Funeral director Frank Pelly Vose
(b) Address 52 N. Main St. Huntington W. Va.

19 (a) Sept 2 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to Sept 1 1945 and that I last saw h[illegible] alive on Sept 1 1945.

Immediate cause of death: Acute Cardio-Respiratory decompensation — Duration: 1 day
Due to: Prostatic Hypertrophy with Urinary Bladder — Duration: 1 wk.
Due to: obstruction — Duration: ?
Other Conditions: Chr. Endocarditis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Omar E. Staggers, M.D.
Address 1001 E. Pratt St. Date signed 9/4/45

VS 150

137a

G32043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

Registered No. G32043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct if is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Pennsylvania (b) County ~~Baltimore~~
(c) City or town ~~Baltimore~~ Ellwood City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 Wampum Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Yolanda Mary Carmosino

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1938

8. AGE: Years	Months	Days	If less than one day
6	11	10	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation 0
11. Industry or business

FATHER
12. Name Orlindo Carmosino
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Carmosino
15. Birthplace Italy

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4-45 (month) (day) (year)
(c) Cemetery or crematory Ellwood City
Location Ellwood City, Penn.

18 (a) Funeral director Frank Della Vore
(b) Address 52 N. Morley St.

19 Filed SEP 4 1945 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, at 10 37 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1945, to Aug. 31 1945, and that I last saw her alive on Aug. 31 1945

Immediate cause of death
Post-operative pleural effusion & bronchopleural fistula — Duration
Due to
Due to Bronchiectasis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug. 16, 1945
Major findings of operation: Bronchiectasis, left lower lobe
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchizah Seragusa M.D.
Address U. M. H. Date signed Aug 31, 45

VS 150

G32044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

✓ G32044

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Sinai Hospital

(c) Hospital or institution: Monument & Rutland Ave 15 59

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4129 Norfolk Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Schapiro

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Rachel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Samuel Schapiro
13. Birthplace Russia

MOTHER
14. Maiden Name U.K.
15. Birthplace Russia

16 (a) Informant Louis Schapiro
(b) Address 4129 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2, 1945 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1945, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1945 to 9-1 1945 and that I last saw him alive on 8-31 1945.

Immediate cause of death Respiration failure

Due to Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. Steinbach M. D.

Address Sinai Hospital Date signed 9-1-45

VS 150

X

G32045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G32045
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Lloyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1945

8. AGE: Years	Months	Days	If less than one day
		30 24	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles S. Lloyd
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Elizabeth Casey
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Chestnut Ridge

18 (a) Funeral director John Bruce Sons
(b) Address 610 York Road Towson

19 (a) Sept 1 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945, at 9:42 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1945 to Sept 1 1945, and that I last saw her alive on Sept 1 1945

Immediate cause of death Dehydration

Duration 5 days

Due to Acute Nutritional Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Streeter M. D.
Address Date signed

VS 180

G32046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32046 Registered No. 930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's page is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSP. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 UNION AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MR. DANIEL E. WANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 1, 1871

8. AGE: Years	Months	Days	If less than one day
74	8 7	0 29	hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name DANIEL WANN
13. Birthplace MD.

MOTHER
14. Maiden Name ELIZABETH WHEELER
15. Birthplace MD.

16 (a) Informant George Wann
(b) Address 313 E 20 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 45 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park,
Location Baltimore Md

18 (a) Funeral director Frank W Leary
(b) 1945 814 N 36 St

19 (a) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 31 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1945, to 8-31 1945, and that I last saw HIM alive on 8-31 1945.

Immediate cause of death Congestive heart failure due to hypertensive Cardiovascular Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions Emphysema & Arteriosclerosis, Senile. — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Lord III M.D.
Address Univ. Mem. Hosp. Date signed 8/31/45

VS 130

Wm. D. Lord III

G32047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G32047

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Carroll
(c) City or town WESTMINISTER (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** MRS. ANNA ELIZABETH MUMMAUGH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife LAWRENCE MUMMAUGH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 13, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	17	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRANK YELNIEK
13. Birthplace CZECHOSLAVAKIA

MOTHER
14. Maiden Name BARBARA MICHAEL
15. Birthplace CZECHOSLAVAKIA

16 (a) Informant Leslie Mummaugh Jr
(b) Address R. No. 4 Westminster

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 9-3-45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location BALTIMORE MD

18 (a) Funeral director FRANK CVACH & SON
(b) Address 900 N. CHESTER ST. Baltimore MD

19 (a) (Date rec'd by registrar) (b) Registrar

P 2-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 30 1945, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw her alive on AUG 30 1945

Immediate cause of death UREMIA

Due to RENAL INSUFFICIENCY

Due to NEPHRECTOMY 12 YRS AGO. RENAL LITHIASIS & HYDRONEPHROSIS OF

Other Conditions REMAINING KIDNEY HYPERTENSIVE CARDIOVASCULAR DISEASE
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Snyder, Jr.
Address Union Memorial Hospital Date signed 8/30/45

1330

G32048 ✓ G32048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Bloom st
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Bloom st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Claude Waddy Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1-44

8. AGE: Years 2 hr | Months | Days | If less than one day 2 hr. min.

9. Birthplace 519 Bloom
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Claude Waddy

13. Birthplace Charlotte N. C.

MOTHER 14. Maiden Name Bernice Ivy Randall

15. Birthplace Baltimore Md

16 (a) Informant Bernice I Randall

(b) Address 519 Bloom St

17 (a) V (Burial, cremation, or removal) (b) Date thereof 9-2-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk

Location Balto County

18 (a) Funeral director Mr Geo H. Holland

(b) Address 1631 Edmondson Ave

19 (a) SEP 2 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/44 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1-44 5 A.M. 9/1-44 7 A.M. and that I last saw h alive on 19

Immediate cause of death (a) Skull Fracture
Secondary Hemorrhage
Due to (Concussion)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burr Roberts M. D.

Address 2132 Druid Hill Ave X Date signed 9/1/44

G32049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G32049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 St. Albans Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Miller Arnold R. Miller Arnold

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	No	Male	White	Married

6 (b) Name of husband or wife Grace E. Arnold
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) August 26, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	5	hr. min.

9. Birthplace Loudon County, Va. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Finicial Secretary

FATHER
12. Name Eliu Sheldon Arnold
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Mason Miller
15. Birthplace Virginia

16 (a) Informant Mrs. Grace E. Arnold
(b) Address 107 St. Albans Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 4529 Liberty Heights Ave.

19 (a) Filed 1945 (b) by registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 8-31-45

X

G32050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G32050 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SOUTH BALTO. GEN. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. Hall
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 W. HUGHES ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	MARRIED

6 (b) Name of husband or wife MARY TURNER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 15 - 1875

8. AGE: Years	Months	Days	If less than one day
70		15	hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)
10. Usual Occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name James Turner
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Baltimore Md

16 (a) Informant Ellen Turner
(b) Address 102 W Hughes Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1. 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Sarah L Brown - Son
(b) Address 1080 Montgomery Street

19 (a) Huntington Williams, Md (Date rec'd by registrar)

SEP 1 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 30 1945, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1PM Aug 30 1945, to 3:50 PM Aug 30 1945, and that I last saw him alive on Aug 30 1945.

Immediate cause of death	Duration
PULMONARY EDEMA	2 HRS.
Due to HEART FAILURE	?
Due to	
Other Conditions LUETIC AORTITIS, ASTHMA	13 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Wheeler M. D.
Address SOUTH. BALTO. GEN. HOSP. Date signed Aug 30 '45

G32051 ✓ G32051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 8th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 8th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1944

8. AGE: Years	Months	Days	If less than one day
1	1	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Clifford L. King
13. Birthplace Pattsburg Va

MOTHER
14. Maiden Name Grace C. Johnson
15. Birthplace Emmitsburg Md

16 (a) Informant Clifford L. King
(b) Address 3715 8th St

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Montrose Minnesota

18 (a) Funeral director Milburn Co Inc
(b) Address 2100 Pratt St

19 (a) Sept 2 1945 (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 1, 1945 M.
(b) Where did injury occur? 3718 8th St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Drowned in bath tub

23. Signature Robert L. Slaton M.D.
Medical Examiner.

Date signed 9-2-45

Registrar

VS 151

EP

X

Please make entries in black ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G32052
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Maryland Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Parks

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice Todd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1894

8. AGE: Years	Months	Days	If less than one day
51	5	21	hr. min.

9. Birthplace Holland Island Dorchester Co, Md
(Town, county, and state)

10. Usual Occupation Waterman

11. Industry or business

FATHER
12. Name Wm. J. Parks
13. Birthplace Holland Island Dorchester Co

MOTHER
14. Maiden Name Ella Chelton
15. Birthplace Fairmount Md

16 (a) Informant Mrs. Wm. J. Parks
(b) Address Cambridge, Md

17 (a) Removal (b) Date thereof 9-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Summerfield Park
Location Crisfield, Maryland

18 (a) Funeral director John C. Bradshaw
(b) Address Crisfield, Md

19 (a) SEP 2 1945 (b) Huntington Williams M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Compound comminuted fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 1, 1945
(b) Where did injury occur? U.S. Marine Hosp
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? No
(d) Means of injury Fall from window

23. Signature Robert L. Frazier M.D.
Medical Examiner.
Date signed 9-2

Please write plainly, with indelible pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G32053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) L

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Paca St
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Miss Lydia E Spence

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	-	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business

FATHER
12. Name Joseph Spence
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret E. Lawerence
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Bessie L Spence
(b) Address 626 S. Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

SEP 2 - 1945 (Date received by Registrar) (By) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1945; at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 23 1945, to September 1 1945; and that I last saw h.r alive on Sept. 1 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions Fractured Femoral neck, left	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 22a
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 23 1945
(c) Where did injury occur? 626 S. Paca St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? No
(e) Means of injury Fell to floor

23. Signature C. M. Caudill M. D.
Address Maryland General Hospital Date signed 9-1-45

VS 3

Approved: Robert Lee Fraser M.D. Baltimore 1, Md. Sept 2 1945

G32054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G32054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E 25th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estie Pearl Stick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife J. Monroe Stick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/1876

8. AGE: Years	Months	Days	If less than one day
69	6	10	hr. min.

9. Birthplace Seitzland York Co. Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dr. W.H. Fair
13. Birthplace Seitzland York Co. Pa.

MOTHER
14. Maiden Name Almira Jane Seitz
15. Birthplace Seitzland York Co. Pa.

16 (a) Informant Mrs Gordon M.F. Stick
(b) Address Glenarm Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Stone Church
Location Broadbecks Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received by registrar) (b) Registrar

SEP 2 1945

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/ 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1935 to Sept 1 1945 and that I last saw h[illegible] alive on Aug 30 1945.

Immediate cause of death	Duration
Congestive Heart Failure	2 mos.
Due to Aortic Aneurism	6 yrs
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S Beck M. D.
Address 101 E 23rd St Date signed 9/2/45

G32055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32055 Registered No. 157a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Lambertville (If outside city or town limits, write RURAL and give town)
(d) Street No. 23 Perry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** William A. Matuella

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-45

8. AGE: Years	Months	Days	If less than one day
	4	11	hr. min.

9. Birthplace N. J. (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert R Matuella
13. Birthplace Pa

MOTHER
14. Maiden Name Margaret Carencro
15. Birthplace

16 (a) Informant St. Joseph Hosp.
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)
(c) Cemetery or crematory Hazelton Penn
Location Hazelton Pa

18 (a) Funeral director L. J. Ruch
(b) Address 5306 Harford Balto Md

19 1945 (b) Huntington Williams Md
Registered by registrar.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1945, at 6:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945 to 9-2 1945, and that I last saw h-- alive on 9-2 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Spina Bifida Hydrocephalus

Due to Spastic Paraplegia

Other Conditions Broncho. pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.
Address St. Josephs Hosp Date signed 9-2-45

G32056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G32056
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Holbrook St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 81 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Holbrook St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Harlow Oates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 81 | Months — | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Micheal Harlow
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Nagle
15. Birthplace Ireland

16 (a) Informant Mrs M. Bowerman
(b) Address 1708 Holbrook, Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.3.1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location

18 (a) Funeral director Mary W Weedfeld
(b) Address 501 E 22nd St

19 (a) 1945 (Date received by registrar) (b) Huntington Williams Md (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1945, at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/ 1945, to 8/29/ 1945, and that I last saw h alive on 8/30/ 1945

Immediate cause of death	Duration
Myocardial Insufficiency	24 hrs.
Due to Myocarditis -	1 yr.
Due to Generalized Arteriosclerosis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Meeks M.D.
Address 887 E 22nd St Date signed 9/1/45

G32057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G32057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Vorwell St. (CARSNER)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathias Erdmon

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mrs. Mathias Erdmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1871

8. AGE: Years	Months	Days	If less than one day
71	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Corbe Lawns & Gardens
11. Industry or business

FATHER
12. Name George M. Erdmon
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Blakely
15. Birthplace Baltimore, Md.

16 (a) Informant Wife
(b) Address 1637 Vorwell St. City, 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Lafayette Mt.

18 (a) Funeral director Wilhelm Bros. Inc.
(b) Address 1244 Park Ave.

19 (a) Filed [illegible] 1945 (b) Registrar [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2, 1945, at 3:42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1945 to Sept. 2 1945 and that I last saw h[illegible] alive on Sept 1 1945

Immediate cause of death: Cerebral hemorrhage accident — Duration: 42 hrs.

Due to: Generalized arteriosclerosis

Due to:

Other Conditions: Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Boyle B. Braid M. D.
Address 2-2-45 Date signed 9-3-45

VS 150

X

G32058 G32058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. ____

To #35181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ____
(c) Hospital or institution: Baltimore city Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 E. Fort Avenue (If rural give location)
(e) Citizen of foreign country? ____ (Yes or No) If yes, name country ____

3 (a) FULL NAME Freda Yesker

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Charles
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1926

8. AGE: Years	Months	Days	If less than one day
18	8	16	____ hr. ____ min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation ____
11. Industry or business ____

FATHER
12. Name Emory Ruark (d)
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary F. King
15. Birthplace Kentucky

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annex Irvington Md

18 (a) Funeral director Wilson Lee Inc
(b) Address 1217 E. Fort Ave

1945 (b) Signature of local reg'r rec'd by registrar Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1945, at 4:10A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 18, 1945 to Sept. 2, 1945 and that I last saw her alive on Sept. 1, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Franklin Harland M. D.
Address 1-E-10 Date signed 9/2/45

VS 150

G32059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G32059 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mechanic & Lexington
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Whitmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive A Phelps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ George L. Phelps
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1906

8. AGE: Years	Months	Days	If less than one day
39	3	0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Ernest Benton
13. Birthplace Md

MOTHER
14. Maiden Name Clara Webster
15. Birthplace Md

16 (a) Informant George L. Phelps
(b) Address 1028 Whitmore Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Friendship
Location A. A. Co. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 9-5-1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945, at 3 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1945 to Sept 1 1945, and that I last saw her alive on Sept 1 1945.

Immediate cause of death	Duration
Uremia	
Due to Chronic Glomerulonephritis	
Lobar pneumonia	
Due to Hypertensive Cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Left kidney Left adrenal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lester L. Baldwin
Address West Baltimore General Hospital Date signed 9/4/45

Bk white
532 E North ave
G32060

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G32060 Registered No.

'PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 E. North ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 E North Ave. (If rural give location)
(e) Citizen of foreign country? C (Yes or No)
If yes, name country

3 (a) FULL NAME Susie C. DeTreville

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	W

6 (b) Name of husband or wife Richard H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17-1859

8. AGE: Years	Months	Days	If less than one day
85	9	19	hr. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name James A. Wallace
13. Birthplace Kentucky

MOTHER
14. Maiden Name Cornelia Gant
15. Birthplace Kentucky

16 (a) Informant Richard E DeTreville
(b) Address 3609 Mohawk ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md

18 (a) Funeral director William Cook Inc
(b) Address 1717 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Aug 31 1945, and that I last saw h[er] alive on Aug 31, 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	7 days
Due to Hypertension	6 mos.
Due to Generalized Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature [illegible] M. D.
Address 532 E 22nd St Date signed 9/4/45

VS 150

G32061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G32061
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4025 Pennington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4025 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick F. Stroh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Katherine Stroh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1881

8. AGE: Years 64 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machanist

11. Industry or business Md. Car Wheel Co.

FATHER
12. Name Daniel Stroh
13. Birthplace Germany

MOTHER
14. Maiden Name Justine Unkel
15. Birthplace Germany

16 (a) Informant John W. Stroh
(b) Address 4025 Pennington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Handy, Inc.
(b) Address 715 Light St.

19 (a) (Date received by registrar) (b) Registrar

SEP 3 - 1945

Arlington Williams, M.D.

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 19 44, to 8/31 19 45, and that I last saw h[illegible] alive on 8/31 19 45.

Immediate cause of death	Duration
Cardiac failure	
Due to Cardio vascular renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.

Address 1212 E. Monument Date signed 9/1/45

X

G32062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G32062
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Patterson Ave
(c) Hospital or institution: St. Agnes 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 W. Lombard st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent White Waitaukaitis

3 (b) If veteran, name war None
3 (c) Social Security Account No. 215-07-2476

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ann White Beloved
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) Dec 7. 1882
8. AGE: Years 63 | Months 9 | Days | If less than one day ____hr. ____min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Clothing

FATHER
12. Name Peter Waitaukaitis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Agnes
15. Birthplace Lithuania

16 (a) Informant Mrs Anna Waitaukaitis
(b) Address 1128 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bloch Road

18 (a) Funeral director Thos. J. Kenny
Address Edmondson & Gilmor

19 (a) SEP 3 - 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 8/30 19 45.

Immediate cause of death: Cardiac failure — Duration
Due to: hypertrophied heart
Due to: arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Kalish M.D.
Address 4 Ogden Apts Date signed 9/5/45

Huntington for Williams, M.D.

VS 150

G32063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 C

G32063 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Hoffman Sts

(c) Hospital or institution:

St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2411 Hamilton Ave.

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Diane Hanson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Premature baby

11. Industry or business

FATHER

12. Name EINAR ERIK HANSON

13. Birthplace Sweden

MOTHER

14. Maiden Name Katherine W. Ghering

15. Birthplace Baltimore, Md.

16 (a) Informant Father

(b) Address 2411 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto Md

18 (a) Funeral director [illegible] Funeral Home

(b) Address [illegible] Orleans St

SEP 3 – 1945 Washington Millinery MR (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945, at 6:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept. 2 1945, and that I last saw her alive on Sept. 2 1945.

Immediate cause of death Prematurity

Due to Central placenta praevia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. E. Robertson M. D.

Address St. Josephs Hosp Date signed 9-2-45

VS 150

X

G32064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G32064

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town North Linthicum (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Patapsco Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Carl Stefan Zondler, Jr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-45

8. AGE: Years | Months | Days | If less than one day: 34 hr. 9 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Carl Stefan Zondler
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Josephine Lieb
15. Birthplace Balto, Md.

16 (a) Informant Elizabeth Zondler
(b) Address 4 Patapsco Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Fulton Funeral Home Inc
(b) Address 1214 E. Fort Ave
(c) Hunter Williams, MD

(Date rec'd by registrar) SEP 3 1945 Registrar

VS 4a

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1945 to 9-1 1945, and that I last saw him alive on 9-1 1945.

Immediate cause of death: Congenital Atelectasis — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 9-5-45

G32065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1178

G32065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days): Life

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No.: 4128 Forest Park Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country:

3 (a) FULL NAME: SYLVAN WILENZICK

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years: 22 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Albany, Ala.

(City, county, and state)

10. Usual Occupation: Salesman

11. Industry or business:

FATHER 12. Name: Louis Wilenzick

13. Birthplace: Russia

MOTHER 14. Maiden Name: Dora Shapiro

15. Birthplace: Russia

16 (a) Informant: Louis Wilenzick

(b) Address: 4128 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-3-45 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Friendship

Location:

18 (a) Funeral director: J. C. Rewis Inc

(b) Address: 1739 E. Balto. St

19 (a) (Date received by registrar): 9-3-1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-1 1945, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1945 to 9-1 1945 and that I last saw him alive on 9-1, 1945.

Immediate cause of death: Fibrin pulmonitis

Due to: Complications of bile duct (common)

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Duodenal ulcer

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Stanley R. Stanbaul M. D.

Address: Sinai Hospital Date signed: 9-2-45

X

367363 G32066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V121a

G32066 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 E. Eager St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	black	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 3 - 10

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ben Booker
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Elizabeth ?
15. Birthplace Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Q. A. County, Md.

18 (a) Funeral director Mrs. Robert A. Ellender
(b) Address 129 Charlestown Hill St, Md

19 (a) (Date received by registrar) (b) Registrar

FP 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 30 1945, at 3:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25- 1945 to 8-30 1945 and that I last saw h. alive on 8-30 1945

Immediate cause (a) Respiratory failure
Due to Uremia
Due to Nephrosclerosis
Due to Hypertensive Cardiovascular Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Balto. Md. Date signed 8/30/45

X

G32067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G32067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2362 McCulloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 2362 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Abraham Averbuch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 77 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Reverend

11. Industry or business

FATHER 12. Name Issachar Dov
13. Birthplace Russia

MOTHER 14. Maiden Name Sivca
15. Birthplace Russia

16 (a) Informant Anna Averbuch
(b) Address 2362 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Hamilton or Belair Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1696 Dolphin St

19 (a) 9-3-1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1945, at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4-1943 to 9-2-1945 and that I last saw h[illegible] alive on 9-2-1945

Immediate cause of death	Duration
Coronary Sclerosis	
myocardial insufficiency	1943
Due to arteriosclerosis	
Hemoplegia	5 days
Due to Cerebral Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.A. Michelson M. D.
Address 2230 Eutaw Pl Date signed 9/3/45

VS 150

G32068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Warner Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Warner Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Partlow

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 10 1889
8. AGE: Years 56 | Months 5 | Days 20 | If less than one day hr. min.
9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hays Robinson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Eliza Good
15. Birthplace South Carolina

16 (a) Informant Essie Barrett
(b) Address 908 Warner Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3, 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Monument Street

19 (a) (Date filed by registrar) (b) Registrar

Huntington Maryland

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 30 1945, at 10:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1945 to Aug. 30 1945, and that I last saw h er alive on - 19

Immediate cause of death: Valvular Heart Disease — Duration

Due to (or a)

Due to

Other Conditions: Acute indigestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J B M Roberts M. D.
Address 134 W Lex Date signed 9/1/45

Please correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

8-1945

G32069

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G32069
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Grayson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Grayson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel A. Belt

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Howard L. Belt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17. 1889

8. AGE: Years	Months	Days	If less than one day
55	11	15	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles M. Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Corbett
15. Birthplace Md.

16 (a) Informant Howard L. Belt
(b) Address 3005 Grayson St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director G. Howard Strong
(b) Address 2207 W. North ave Baltimore, Md

19 (a) (b) Registrar
Registered by registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 10 P M

21. I certify that I took charge of the remains described above, held an Investigation thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic hypertrophic degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature L. Eustace Fraser M.D.
Medical Examiner.
Date signed 9-2-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G32070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Oliver Sts.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) Ever

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4703 Elsrode Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard V. Knapp.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1284

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/12.

8. AGE: Years	Months	Days	If less than one day
33	5	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Peter Knapp

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Anna Diehl

15. Birthplace New York State

16 (a) Informant Alice V. Knapp

(b) Address 4703 Elsrode Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 45 (month) (day) (year)

(c) Cemetery or crematory Arlington Memory Gdns Location

18 (a) Funeral director Charles C. Powell

(b) Address 2427 Edmondson Ave

19 (a) 1045 (Date received by registrar) Hortense Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 9/1 1945 and that I last saw him alive on 9/1 1945

Immediate cause of death Respiratory Failure — Duration

Due to Pulmonary Embolus

Due to Diffused Peritonitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/18/45

Major findings of operation: Acute Gangrenous Appendix & Peritonitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. T. Emmett M.D.

Address St. Joseph's Hosp Date signed 9/1/45

VS 150

G32071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32071

Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton and Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New York (b) County

(c) City or town Seneca Falls N.Y. (If outside city or town limits, write RURAL and give town)

(d) Street No. R.F.D. #1 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Betty J Plate

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1926

8. AGE: Years 19 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Fayette N.Y. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER

12. Name George Plate

13. Birthplace Fayette, N.Y.

MOTHER

14. Maiden Name Lena M. Rogers

15. Birthplace Fayette N.Y.

16 (a) Informant Hospital Records

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/3/45 (month) (day) (year)

(c) Cemetery or crematory Waterloo N.Y.

Location

18 (a) Funeral director Wm. J. Tiekner & Sons

(b) Address North & Pa. Aves.

1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1945, at 9.52 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1945 to 9/2 1945, and that I last saw her alive on 9/2 1945

Immediate cause of death	Duration
Diabetic Acidosis & Coma	
Due to Diabetes Mellitus	
Due to Coma induced by Pneumonia & post. Bacteremia	
Other conditions (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] D

Address [illegible] Date signed 9/3/45

VS 190

Huntington Williams M

G32072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No. G32072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Greenmount ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles P. Shettle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ada Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Office Clerk
11. Industry or business

FATHER
12. Name Daniel Shettle
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Agnes Landeen
15. Birthplace Baltimore Md

16 (a) Informant Mrs Ada M. Shettle
(b) Address 3001 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 6 - 45 (month) (day) (year)
(c) Cemetery or crematory Loreland Mem.
Location

18 (a) Funeral director L. J. Rush
(b) Address 5305 Harford Rd

19 (a) SEP 5 1945 (Date received by registrar) (b) Huntington Hollins, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 2 1945 at 1 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 20 1945 to 9 - 2 1945, and that I last saw him alive on 9 - 2 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Rheumatic C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hosp Date signed 9 - 2 - 45

X

G32073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32073 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Wendover Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Marion Tolson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-4406

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Jos. M. Tolson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1902

8. AGE: Years	Months	Days	If less than one day
42	10	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Steam fitter
11. Industry or business Lloyd E. Mitchell

FATHER
12. Name Jos. T. Tolson
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Virginia Davidson
15. Birthplace Md.

16 (a) Informant Mrs Mary A Tolson
(b) Address 2613 Wendover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Md.

18 (a) Funeral director Leonard J. Peck
(b) Address 1215 W. Lexington St.

SEP 3 1945

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 4:49 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1945 to Sept. 1 1945, and that I last saw him alive on Aug. 31 1945

Immediate cause of death Ca of lung. Bronchogenic Carcinoma — Duration 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug. 21, 45 Thoracotomy

Major findings of operation: Tumor cells in pleural fluid - Ca bronchus, Ca lung

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee, M.D.
Address Union Memorial Hospital Date signed 9/6/45

VS 150

A42847 304
G32074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G32074 / 4 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Lusby
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REGENA SPINNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-24-38

8. AGE: Years	Months	Days	If less than one day
7 years	3	5	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilmer Spinner
13. Birthplace Va

MOTHER
14. Maiden Name Mary Bouldin
15. Birthplace W. Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 6 45 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Calvert Co

18 (a) Funeral director P. C. Sewell
(b) Address Prince Frederick Md

19 (a) Thurlow Weed Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 - 1945 at 2 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1945 to 9-2- 1945.
and that I last saw her alive on 9-2- 19

Immediate cause of death Respiratory failure — Duration
Due to TBC meningitis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.
Address Johns Hopkins Hosp Date signed 9-2-45

VS 150

X

G32075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Memorial Hospital
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Rose Marie Melling

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single ✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-1883

8. AGE: Years	Months	Days	If less than one day
61	1	2	hr. min.

9. Birthplace Washington D. C
(Town, county, and state)
10. Usual Occupation Sister of Charity
11. Industry or business

FATHER
12. Name George Melling
13. Birthplace Washington DC

MOTHER
14. Maiden Name Rose Loughran
15. Birthplace Baltimore, Md.

16 (a) Informant St. Agnes Hospital
(b) Address Caton & Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 N. North Ave.

19 (a) Huntington Williams (b) Registrar
(Date rec'd by registrar) SEP 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945, to Sept 2, 1945, and that I last saw h[illegible] alive on Sept 2 1945.

Immediate cause of death	Duration
Cardiac failure & pulmonary oedema	
Due to Chronic arteriosclerosis	
Cardio vasc. Disease	
Due to	
Other Conditions Embolism to lower abdominal aorta	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Lacey, Jr. M.D.
M. D.
Address St. Agnes Hosp Date signed 9/3/45

G32076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G32076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 McKean Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 McKean Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie C. Norton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband Michael A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Antonio D'Antoni
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Michael Norton
(b) Address 1903 McKean Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Tighey & Sons
(b) Address 1827 N. North Ave.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

SEP 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1945 at 9:33 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Sept 1945, and that I last saw her alive on Aug 20 1945.

Immediate cause of death Carcinoma of Rectum — Duration 3 yrs

Due to

Due to

Other Conditions Arteriosclerotic C.V. disease (Include pregnancy within 3 months of death) — 4 yrs

Date of operation 1942

Major findings of operation: Metastatic Ca of Rectum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Lubinski M. D.

Address 521 Eastern Ave. Date signed 9/4/45

X

G320777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 ✓

Registered No. G32077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Springdale Ave
(c) Hospital or institution:

15-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Edelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Real Estate

FATHER
12. Name Emanuel Edelson
13. Birthplace Russia

MOTHER
14. Maiden Name Mary ?
15. Birthplace Russia

16 (a) Informant Mrs Barnett Shpritz
(b) Address 3616 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1945 (month) (day) (year)
(c) Cemetery or crematory New Britian Conn.
Location

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

SEP 4 - 1945 (Date rec'd by Reg.) Certificate by Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1945, at 9.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3, 1945 to Sept 2 1945 and that I last saw him alive on Sept 2, 1945.

Immediate cause of death Coronary occlusion; Myocardial failure — Duration about 2 yrs.

Due to Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan H. Spritzler M.D.
Address 1810 Eutaw Pl. Date signed 9/5/45

VS 130

G32078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9 1 B

Registered No. G32078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 Harlem ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie D. Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace a. a. Co. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William Taylor
13. Birthplace Md

MOTHER
14. Maiden Name Mary Chauncey
15. Birthplace Md

16 (a) Informant Ethel Spencer
(b) Address 1110 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A Stamper
(b) Address 942 W. Fitz St

19 (a) SEP 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1945 at 12:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased Aug 24 1945 to Sept 3 1945, and that I last saw h[illegible] alive on Sept 1 1945.

Immediate cause of death Cerebral Embolism — Duration 5 hrs

Due to

Due to Pneumonia — 3 days

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Traucker M. D.
Address 1111 Lee Date signed 9/3/45

VS 150

X

ARISKER Bell

632079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 632079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Peach St
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Peach St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arriker Bell.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Miles Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/[illegible]

8. AGE: Years 39 | Months 10 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Ernest Gray
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Dixon
15. Birthplace Md.

16 (a) Informant Miles Bell
(b) Address 1007 Peach St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Hill St

19 (a) SEP 4 1945 (Date received by registrar) (b) Registrar's signature for Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 2 1945 to Sept 2 1945, and that I last saw her alive on Sept 1 1945.

Immediate cause of death Chronic Myocarditis — Duration 6 mo.
Due to Hypertension
Due to Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Frankel M. D.
Address 1 W Saratoga Date signed 9/3/45

X

G32080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104 B

Registered No. G32080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County (over)
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4632 Hartford Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Fontanazza (also known as Vincenzo Fontanazza)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Rose Fontanazza
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1892

8. AGE: Years	Months	Days	If less than one day
52	9	23	24 hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation (Clerk) Cabinet-maker
11. Industry or business National Steel Stamping Co. (Custom House)

FATHER
12. Name Mariano (Marion) Fontanazza
13. Birthplace Italy

MOTHER
14. Maiden Name Gaetana (Emanna) (Colicigna) Colasanna
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 4632 Hartford Road

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 4 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1945, at 4:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1945, to Sept 3 1945, and that I last saw him alive on Sept. 3, 1945

Immediate cause of death	Duration
Cavernous sinus Thrombosis	24 hrs.
Due to Maxillary abcess	2 weeks
Due to Abscessed teeth	?
Other Conditions Locked temporo-mandibular joints (Include pregnancy within 3 months of death)	
Date of operation Sept. 1, 1945	
Major findings of operation: Abcess extended up to & around temporo-majeur	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent De P. Bozzuto M.D.
Address Mercy Hospital Date signed 9/4/45

VS 150

G32081 ✓ G32081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hotel Morva Charles & Hamilton
(c) Hospital or institution: Union Memorial Hosp. 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Hours
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Morva Charles & Hamilton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McKnight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1901

8. AGE: Years	Months	Days	If less than one day
44	6	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Count Steamfitter

11. Industry or business

FATHER
12. Name Richard J. McKnight (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Jordan (D)
15. Birthplace Baltimore Md.

16 (a) Informant Self.
(b) Address

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) SEP 4 - 1945 (Date rec'd by Registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/1945 to 9/1/1945.
and that I last saw h. l. alive on 9/1/1945.

Immediate cause of death Hemorrhage of
Shock

Due to Rupture of ectopic pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9

Major findings of operation: D

of autopsy: Large tumor mass from ruptured

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gayle G Arnold M.D.
Address UMH. Date signed 9-2-45

VS 180

G32082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G32082

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Morrell Park Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Morrell Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Kalinowskas (KALMANSKAS)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4505

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Adam Kalinauskas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Eva ?
15. Birthplace Lithuania

16 (a) Informant Margaret Kalinauskas
(b) Address 1807 Morrell Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Joseph Kamakowski
(b) Address 602 Washington Blvd

19 (a) SEP 4 - 1945 (Date rec'd by registrar) (b) Huntington for Nellie Hall, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1945 at 6:35 P.M.

21. I certify that I took charge of the remains described above, held an A + S thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Shuka M.D. Medical Examiner.
Date signed 9/3/45

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G32083 Registered No. 81a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 736 Ramsey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Beckhardt
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. —
4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11 | 29 | 44
8. AGE: Years | Months 9 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Gilbert Beckhardt
13. Birthplace Balto.
MOTHER 14. Maiden Name Doris Greenfeld
15. Birthplace Balto
16 (a) Informant Gilbert Beckhardt
(b) Address 736 Ramsey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 - 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Edmondson Ave
18 (a) Funeral director Joseph Kassnakes Inc
(b) Address 601 Walk. Blvd
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar
SEP 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 2 1945, at 12:01 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1945 to 9-2 1945, and that I last saw h alive on 9-2 1945
Immediate cause of death Pneumococcal Meningitis — Duration 7 days
Due to
Due to
Other Conditions Abd. Adhesions Partial Obstruction
(Include pregnancy within 3 months of death)
Date of operation 8-27-45
Major findings of operation: Adhesions around Pylorus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 9-2-45

X

G32084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G32084 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 E 28th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 E 28 St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Oberle

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jules Oberle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 18-1858

8. AGE: Years	Months	Days	If less than one day
87	7	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Geo M. Baetz
(b) Address 1811 E 28 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. Co.
Location
18 (a) Funeral director Bernard E Harle
(b) Address 131 E West St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1945, at 3:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1945 to Sept 2 1945 and that I last saw her alive on Aug 1 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 d.
Arteriosclerosis	5 d
Due to Hypertension	5 d
Due to Other Intercurrent Nephritis	5 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature G G A Stevens M. D.
Address 2878 Harford Date signed 9-3-45

X

G32085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 18

G32085

Registered No.

JO #90975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos. 27days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1031 Hillman St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Christine M. Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1892

8. AGE: Years	Months	Days	If less than one day
53	3	26	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Eckert (d)

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Eckert

15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cemetery

Location 2930 Frederick Ave

18 (a) Funeral director Howard N. Bilgis Jr.

(b) Address 4914 Belair Road

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1945, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4, 1944, to Sept. 1, 1945, and that I last saw her alive on Sept. 1, 1945.

	Duration
Immediate cause of death Bronchopneumonia	
Other conditions: Left	
Due to hemiplegia due to	
cerebral Thrombosis	
Due to Tuberculosis of the	
Brain	
Other Conditions Tuberculosis pulmonary	
healed (?)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address BCH Date signed 9/2/45

VS 150

G32086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G32086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert F. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruth V. Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baker Helper
11. Industry or business Roasters Co.

FATHER
12. Name Richard Davis
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Friesel
15. Birthplace Baltimore Md.

16 (a) Informant Ruth V. Davis
(b) Address 608 N. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor ave.

18 (a) Funeral director Howard N. Bight Jr.
(b) Address 4914 Belair Road

19 (a) SEP 4 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 11 45 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fisher M.D. Medical Examiner.
Date signed Sept. 3 1945

VS 151

X

G32087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G32087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Arlington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Estta Miller

3 21143

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-45

8. AGE: Years	Months	Days	If less than one day
	5	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Shelton Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Dorothy Blackwell
15. Birthplace Va.

16 (a) Informant Rennda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Wm Francis A Hensley
(b) Address 578 W Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 4 1945

VS 160

Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-31- 1945 at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-31- 1945 to Aug-31 1945 and that I last saw h[illegible] alive on Aug-31 1945

Immediate cause of death Shock — Duration

Due to Dehydration

Due to Diarrhea

Other Conditions Otitis media

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Bolson Assistant Resident M. D.
Address [illegible] Date signed 9/1/45

X

632088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eaton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eaton Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Benjamina Denton

3 (b) If veteran, name war N.

3 (c) Social Security Account No. none

4 Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1849

8. AGE: Years 96 | Months 6 7 | Days 7 | If less than one day hr. min.

9. Birthplace Princes Anne Co Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Denton
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Margaret Davy
15. Birthplace Va.

16 (a) Informant Anna W. Shaffer
(b) Address 2472 Shirley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St. Huntington for Williams, Md.

19 (a) SEP 4 1945 (b) Registrar

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945 at 8 A.D. M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 25 1945 to Sept 1 1945 and that I last saw her alive on Aug 31 1945

Immediate cause of death

Due to Cardiac Dilatation — Duration several years.

Due to Old age.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. C. Blake M. D.
Address Med. Arts Bldg Date signed

G32089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G32089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MONUMENT St. & RUTLAND AVE

(c) Hospital or institution: SINAI HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)

(d) Street No. 956 W. SARATOGA St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Samuel Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
26			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation mechanic

11. Industry or business Glazier & Mirrors

FATHER

12. Name Nathan Cohen

13. Birthplace Russia

MOTHER

14. Maiden Name Ida -

15. Birthplace Russia

16 (a) Informant Nathan Cohen

(b) Address 956 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)

(c) Cemetery or crematory Workman Circle

Location Shelley - Mt. Carmel

18 (a) Funeral director Jos. Lewis Inc

(b) Address 1439 E. Balto. St

19 (d) SEP 4 - 1945 (Date rec'd by registrar) (e) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1945, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19 45, to Sept. 19 45, and that I last saw h alive on Sept. 3 19 45.

Immediate cause of death	Duration
acute intestinal obstruction	
Lymphoblastic	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard [illegible] M. D.

Address Date signed 9-2-45

VS 150

X

G32090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

G32090

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Duke and Raymond

(c) Hospital or institution:

West Balto. Gen. Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 19

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5720 Narcissus Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Bernice Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/4/ 1920

8. AGE: Years 15 | Months 2 | Days 29 | If less than one day: hr. min.

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER

12. Name Morris Goldberg

13. Birthplace Russia

MOTHER

14. Maiden Name Anna

15. Birthplace Russia

16 (a) Informant Morris Goldberg

(b) Address 5720 Narcissus Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew Cem

Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E Balto St

19 SEP 4 - 1945 (Date rec'd by city or cnty) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/45 19 , at 4.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/45 19 , to 9/3/45 19 , and that I last saw h alive on 9/3/45 19 .

	Duration
Immediate cause of death: Respiratory failure	
Due to: Toxemia	
Due to: Inflammatory lesions of the Caecum and Appendix	1 week
Other Conditions: Abortion ?	

(Include pregnancy within 3 months of death)

Date of operation 8/27/45

Major findings of operation: Necrotic Caecum & Appendix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James A. Dawkins M. D.

Address W.B.G.H. Hospital Date signed 9/3/45

VS 150

G32091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G32091

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Westwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Marks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Riga Latvia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Boris Lask
13. Birthplace

MOTHER
14. Maiden Name Sarah Lask
15. Birthplace

16 (a) Informant Mrs Fanny Marks
(b) Address 2100 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Baltimore St

19 (a) 1 — 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1945, at 8:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1945 to Sept 3 1945, and that I last saw h in alive on Sept. 1 1945.

Immediate cause of death Cardiac failure — Duration

Due to Myocarditis — Duration

Due to Arteriosclerosis - generalized. — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 314 - W. North Ave Date signed 9/4/45

VS 150

G32092

BALTIMORE CITY HEALTH DEPARTMENT

AB-93922

CERTIFICATE OF DEATH 47c

Registered No. G32092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos. 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 906 N. Dallas St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Howard Jackson Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9- 1887

8. AGE: Years	Months	Days	If less than one day
58	0	22	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Jackson (D)

13. Birthplace N.C.

MOTHER 14. Maiden Name Lettie Harris (D)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Langsdown, Md.

18 (a) Funeral director Charles R. Law

(b) Address 202 Madison Ave.

19 (a) [illegible] (b) Registrar Huntington Williams, M.D.

SEP 4 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31- 1945 at 12.20 P

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29- 1945 to 8-31 1945.

and that I last saw h im alive on 8-31- 1945.

Immediate cause of death Respiratory failure

Due to Tumor metastasis to brain

Due to Tumor of adrenal (Left) Medullated tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: [illegible]

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jonathan Howland M. D.

Address B.C.H. Date signed 9/2/45

VS 150

G32093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G32093

Registered No. 838

CHK-15754

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19- 8- 9
(e) Length of stay in Baltimore (yrs., mos., or days) 84- 7- 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Homeless (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Giles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31-1861

8. AGE: Years	Months	Days	If less than one day
84	7	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John E. Giles
13. Birthplace Baltimore-Md.

MOTHER
14. Maiden Name Sarah A. McNulty
15. Birthplace Baltimore-Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Robert J. Little
(b) Address 2701 Edmondson Ave

19 (a) (b) Registrar

(Certificate rec'd by registrar) SEP 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2- 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1945 to Sept. 2 1945, and that I last saw h im alive on Sept. 2 1945

Immediate cause of death Thrombosis Rt. middle cerebral artery ?

Due to

Due to

Other Conditions Microcytic hypochromic anemia (include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 20 E. Mt. Date signed 9/3/45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G32094

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Edgevale Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-13
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Edgevale Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Clara H. Tennant

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age | | | years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1945

8. AGE: Years	Months	Days	If less than one day
75	6	14	hr. min.

9. Birthplace Gainsborough, W. Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alexander W. Tennant
13. Birthplace Scotland

MOTHER
14. Maiden Name Nannie Poisol Tennant
15. Birthplace W. Va.

16 (a) Informant Dr. Edgar H. Northam
(b) Address 1918 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Road

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by Registrar) (Registrar) Washington Williams, M.D.
SEP 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1945 at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1945 to Sept 2nd 1945, and that I last saw her alive on Sept 1st 1945.

Immediate cause of death	Duration
Cardiac Asthenia	3 days
Due to Chronic Nephritis	3 years
Due to Arteriol Sclerosis	15 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no While at work? (Specify type of place)
(e) Means of injury no

23. Signature Herbert E. Zapp, M.D.
Address 3048 W. North Ave. Date signed 9/4/45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

877

G32095 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Coldspring Lane
(c) Hospital or institution:
Coldspring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~~~ Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Clarendon Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Florence May Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1871

8. AGE: Years	Months	Days	If less than one day
73	10	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation milliner -- retired

11. Industry or business

FATHER
12. Name Richard Cromwell Thomas
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Richards
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Harry C. Thomas
(b) Address 3326 Greenmount Ave.

17 (a) Burial (b) Date thereof 9/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. at Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1000 Eutaw Place

SEP 4 - 1945
(Date rec'd by) registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1945, at 7.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept 1 1945, and that I last saw her alive on Aug 31 1945.

Immediate cause of death	Duration
disseminated sclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Perkerson M. D.
Address 2324 Reisterstown Rd. Date signed

Huntington Williams, M.D.

VS 150

X

G32096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

G32096

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 947 S Commerce St. (If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Diana Townsend.

3 (b) If veteran, name war _____

3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife _____
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 4-2-45

8. AGE: Years	Months	Days	If less than one day
	5	-	hr. _____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

FATHER
12. Name Loard Townsend
13. Birthplace md.

MOTHER
14. Maiden Name Harriet Washuta
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1314 N. Central Ave

SEP 4 1945 (b) _____ Registrar
(Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:00 PM 9/2 1945 to 6:45 9/2 1945 and that I last saw here alive on 9/2 1945.

Immediate cause of death	Duration
Circulatory collapse	
Due to acute nutritional disturbance and dehydration	
Due to otitis media	
Other Conditions early pneumonia	

(Include pregnancy within 3 months of death)

Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Margaret Hammond
Address 1 Lt MC Date signed 9/2/45

X

G32097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1181

G32097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eli (Jones) Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-2-12

8. AGE: Years 32 | Months 11 | Days 26 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Eli (Jones) Bryant

13. Birthplace N.C.

MOTHER 14. Maiden Name Mary Bryant

15. Birthplace N.C.

16 (a) Informant Recorder

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Robert E. Young

18 (a) Funeral director E.O.4 N. Carolone St

(b) Address Huntington Williams

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1945 at 7 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to Aug 28 1945 and that I last saw h[illegible] alive on Aug 28 1945

Immediate cause of death: Respiratory Collapse — Duration

Due to Extensive 3° Burns of Trunk, neck, arms, legs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of [illegible] August 26 August 1945

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3/1

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 26 August 1945 8:15 P.M.

(c) Where did injury occur? Balto. Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO

(e) Means of injury Bed clothing caught fire from Cigarette

23. Signature John William Hillman M.D.

Address Johns Hopkins Hospital signed X

Howard J. Mercer, M.D. 28 August 1945

VS 150 SEP 1 - 1945

G32098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G32098 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 300 E 25th St.

(c) Hospital or institution: Union Memorial Hosp. 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28d

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County 3

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 300 E 25th St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Margaret Porcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife John August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1/1847

8. AGE: Years	Months	Days	If less than one day
98	7	1	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name ? Wolt (deceased)

13. Birthplace Germany

MOTHER 14. Maiden Name Lotz Riell

15. Birthplace Germany

16 (a) Informant Mrs Pedrigan

(b) Address 300 E. 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd

18 (a) Funeral director Harry F Walter

(b) Address 4101 E Monument Ave

19 (a) SEP 4 1945 (Registrar's signature) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1945, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/1945 to 9/1/1945 and that I last saw h[illegible] alive on 8/31/1945

Immediate cause of death [illegible] Duration

Due to Bronchopneumonia

Due to Intertrochanteric fracture of right hip.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 12/3

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence Aug 25 1945 M

(c) Where did injury occur? Balto Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No

(e) Means of injury Fall down - alone

23. Signature Howard J. Kenesis, M.D.

Address Union Mem Hosp Date signed 9/1/45 M. D.

VS 180

G32099

JL - 91866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G32099

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 2 13-7

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3821 Pleasant Place (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert N. Dennis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 30, 1867.

8. AGE: Years	Months	Days	If less than one day
78	5	2	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER

12. Name Robert Newton Dennis

13. Birthplace Md.

MOTHER

14. Maiden Name Sarah Jane Greene

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)

(c) Cemetery or crematory Morland Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1945, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 30 1945 to Sept. 2 1945, and that I last saw him alive on Sept. 2, 1945

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to Arteriosclerosis (Generalized)	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia and Arteriosclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret M. Dennis

Address 4940 Eastern Ave. Date signed M 9 D 3/45

Huntington Williams, M.D.

VS 150

G32100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G32100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Vincent St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Layman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1921

8. AGE: Years	Months	Days	If less than one day
23 24	10	1	hr. min.

9. Birthplace Steelton, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Saunders
13. Birthplace Milford, Va.

MOTHER
14. Maiden Name Lucy B. Graham
15. Birthplace Va.

16 (a) Informant William Saunders
(b) Address 511 Lincoln St Steelton Pa.
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Sept. 4 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Harrisburg Pa.
18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St.
19 (a) SEP 4 - 1945 (Date rec'd by registrar) (b) Huntington W. Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1945, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 2d at 2:30 1945 A.M.
(b) Where did injury occur? 5 N. Vincent St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hit on head with axe

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 3 1945

VS 151

X

G32101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

G32101 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 745 Vine St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza Lottie Petty Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1894

8. AGE: Years 51 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Essex Co Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Simon Fisher

13. Birthplace Va.

MOTHER 14. Maiden Name Lottie

15. Birthplace Va.

16 (a) Informant Ezra Petty, daughter

(b) Address Chicago, Ill.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1945, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Less death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diffuse Myocardial Fibrosis

Due to Arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Preston M.D. Medical Examiner.

Date signed 8/21/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 15f

X

G32102

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32102 Registered No. 169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1905

8. AGE: Years 40 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Samuel Johnson.
13. Birthplace Westland, Va.

MOTHER
14. Maiden Name Susie Charles
15. Birthplace Westland, Va.

16 (a) Informant Nellie Johnson.
(b) Address 1507 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5 45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Mulligan
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 45 19 9 A. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-30-45 at 1:30 P. M. 26-6
(b) Where did injury occur? Baltimore Co. Canton R.R. Spur 2.
(c) Did injury occur at home, on farm, industrial place in public place? Industrial. While at work? Yes.
(d) Means of injury KNOCKED FROM TOP OF BOX CAR BY SOMETHING PROJECTING ON PASSING TRAIN.

23. Signature Robert Lee Fraser M.D.
Medical Examiner.

Date signed August 31, 1945.

X

VS 151

Please answer all questions. Physicians: please write the causes of death clearly and legibly.

Spon.—1-12-23—M&T—600 Blks.

G32103

HEALTH DEPARTMENT—CITY OF BALTIMORE G32103

CERTIFICATE OF DEATH. 46B

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 655 Hanover ST., ... WARD)

2-FULL NAME William Johnson

(a) RESIDENCE No. 655 Hanover ST., 22-2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	a	W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Johnson

6 DATE OF BIRTH (month, day, and year) Feb. 2 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Crownsville (State or country) Md

PARENTS

10 NAME OF FATHER Jno. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Johnson

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Mr Walter Johnson. Brother
(Address) 655 Hanover St.

15 Filed SEP 4 - 1945 Huntington Williams M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1945

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1945 to Sept. 1, 1945 that I last saw him alive on Aug. 26, 1945 and that death occurred, on the date stated above, at 4:00 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C. D. Layton M. D.

. 19 (Address) 1522 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery.

DATE OF BURIAL Sept 4 1945

20 UNDERTAKER Mr Kater R Williams

ADDRESS 3237 Schroeder St

G32104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G32104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2505 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Gwynn Falls Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRIETTA M. ROBERTS

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	Female	White	Divorced

6 (b) Name of husband or wife John W. Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1881

8. AGE: Years	Months	Days	If less than one day
64	3	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Slowik
13. Birthplace Austria

MOTHER
14. Maiden Name Josephine --
15. Birthplace Austria

16 (a) Informant Mrs. Eleanor Michaels
(b) Address 3210 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ /45 (month) (day) (year)
(c) Cemetery or crematory St. Stanilaus Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1945 at 1:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1943 to Sept. 2 1945 and that I last saw her alive on Sept. 2 1945

Immediate cause of death	Duration
Left Cerebral Thrombosis	2 wks
Due to Cardio-renal-vascular Disease	11 yrs
Due to Parkinson's Disease	"
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. H. Wilson M. D.
Address 617 W. 40th St. Date signed 9/4/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G32105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Talbot Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William David Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 - 1874

8. AGE: Years	Months	Days	If less than one day
71	0	11	hr. min.

9. Birthplace Wales
(Town, county, and state)
10. Usual Occupation Blacksmith (Retired)
11. Industry or business

FATHER
12. Name David M. Lewis
13. Birthplace Wales

MOTHER
14. Maiden Name Margaret Jones
15. Birthplace Wales

16 (a) Informant Mrs Grover Lewis
(b) Address 2606 Talbot Road

17 (a) V (Burial, cremation, or removal) (b) Date thereof Sep. 6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director H. Gertner Sons
(b) Address North Penna Ave, Balto Md

19 (a) (Date rec'd by registrar) (b) Registrar, M. D.

SEP 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1945, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1945 to 9-2 1945, and that I last saw h[illegible] alive on 9-2 1945

Immediate cause of death Resp. failure

Due to Pulmonary congestion

Due to

Other Conditions Arteriosclerosis.
Surg. Ca of Cæcum
(Include pregnancy within 3 months of death)

Date of operation 8-31-45

Major findings of operation: Appendiceal abscess.

of autopsy: Ca of Cæcum present

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eugene H. Conner M. D.
Address University Hosp Date signed 9-2-45

G32106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓14

G32106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Shell Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIETTE LANE SIEMERS

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Harold Siemers
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	12	hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry T Folks
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name NANNIE Elliott
15. Birthplace England.

16 (a) Informant Mrs. Beulah Ruth
(b) Address 3406 Parkington Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 2 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1945, to 9-2 1945, and that I last saw her alive on 9-2 1945

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gayle B. Arnold M. D.
Address U. M. H. Date signed 9-2-45

VS 190

G3264789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G32107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 944 N Duncan, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Lindt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Henry Lindt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-18-75

8. AGE: Years	Months	Days	If less than one day
70	4	14	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frances Markle
13. Birthplace Md

MOTHER
14. Maiden Name Allice Frame
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Frank Gvach & Son
(b) Address 900 N. Chester St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

SEP 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept -2- 1945 at 1 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1945 to 9-2- 1945 and that I last saw her alive on 9-2- 1945

Immediate cause of death Shock

Due to Bleeding Esoph Varices

Due to Cirrhosis of Liver.

Other Conditions Duodenitis of Cdm. Luetic aortitis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan B. Vance M.D.
Address Johns Hopkins Hospital Date signed 9/2/45

124 B

G32108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 170c

G32108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Maryland Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Glenmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sophia Keating
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Thomas Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name Cathern Kinn
15. Birthplace Ireland

16 (a) Informant John Sclenia
(b) Address 4105 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Frank Coachlon
(b) Address 900 W. Baltimore St.

19 (a) (Date rec'd by registrar) (b) SEP 4 1945 Hunting Town Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945, at 4:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Pelvis right; Compound comminuted fracture of right leg; Fracture

Due to of right arm

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27 5 8:55 P.
(a) Date of injury August 22, 1945 M.
(b) Where did injury occur Belair Rd & Beaumont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Bu Gratden M.D. Medical Examiner.
Date signed 9-2-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632109
478946.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

632109 Registered No. 100 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 Forrest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Jr J Pharaon-

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-10-44

8. AGE: Years	Months	Days	If less than one day
1	6	20	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edgar J Pharaon
13. Birthplace Md.

MOTHER
14. Maiden Name Doris McMillan
15. Birthplace Md

16 (a) Informant See reverse
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

19 (a) Filed Sept 4 1945 (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1945, at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1945 to Aug. 30 1945 and that I last saw him alive on Aug. 30 1945.

Immediate cause of death	Duration
1 Cardiac failure	
Due to 2 Embolism	
Due to Thrombophlebitis	
Other Conditions Recovered from Severe diarrhea. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond M.D.
Address JHH. Date signed 8/30/45

VS 150

G32110
JL - 95741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32110 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S, Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Newton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1860

8. AGE: Years 85 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Braniford

19 (a) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1945 at 7:15 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1945 to Aug. 29 1945, and that I last saw him alive on Aug. 29 1945.

Immediate cause of death cerebral hemorrhage, sole unknown — Duration

Due to Generalized arterio sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address D. C. H. Date signed 8/31/45

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G32111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + greene 56
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2554 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Helen Wilson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	negro	married

6 (b) Name of husband or wife Earl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/30/1913

8. AGE: Years	Months	Days	If less than one day
32	7	3	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John L Robinson
13. Birthplace md

MOTHER
14. Maiden Name Bessie Bands
15. Birthplace md

16 (a) Informant Helen Wilson
(b) Address 2554 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Aphetus
Location Md

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Eastman St

19 SEP 4 - 1945 (Date rec'd by registrar) Remington for Williams MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1945 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1945 to 9/2 1945, and that I last saw her alive on 9/2 1945

Immediate cause of death	Duration
(a) Adenocarcinoma ovary (c)	
(c) Metastasis to	
Due to abdomen & lungs	
Due to	
Other Conditions Emaciation	

(Include pregnancy within 3 months of death)

Date of operation 8/26/45

Major findings of operation: Adenocarcinoma

Cause undetermined

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L T Rowland MD
Address University Hospital Date signed 9/5/45

VS 150

G32112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G32112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 S. CLINTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 S. CLINTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET L. WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife. Samuel Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1862.

8. AGE: Years	Months	Days	If less than one day
83	6	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House-work.
11. Industry or business at home.

FATHER
12. Name Michael Adams
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Schorr
15. Birthplace Baltimore, Md.

16 (a) Informant Marie Williams (Daughter in law)
(b) Address 1109 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Herman Hill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 SEP 4 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 2, 1945, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1945, to Sept 2 1945 and that I last saw h alive on Aug 29 1945.

Immediate cause of death: Cardiac Failure due to Senility

Duration
1 hr.

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. J. Gerry M.D.
Address 6 W. Mulberry Date signed 9/3/45 M.D.

VS 150

G32113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G32113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 N. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie E. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Maurice R. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14th 1876

8. AGE: Years	Months	Days	If less than one day
69	5	18	hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Theodore Ross
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Mollie Adams
15. Birthplace Somerset Co. Md.

16 (a) Informant Maurice R. White
(b) Address Perry Hall Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St.

19 (a) SEP 4 1945 (Date rec'd by registrar) (Huntington Williams Mgr)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 18 1945 to Sept 2 1945, and that I last saw her alive on Sept 1 1945.

Immediate cause of death Carcinoma of Uterus — Duration 15 mos

Due to

Due to

Other Conditions Diabetes and Nephritis — Duration 2 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rosenberg
Address 2025 E North Ave Date signed 9/4/45

VS 180

114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632114 / 63028

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 Bainbridge Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Frank Caponiea Benvin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1897

8. AGE: Years	Months	Days	If less than one day
48	5	18	hr. min.

9. Birthplace ? Italy (Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafaring

FATHER
12. Name Frank Benvin
13. Birthplace Italy

MOTHER
14. Maiden Name Francisco ?
15. Birthplace Italy

16 (a) Informant RECORDS- U. S. Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 1945 (month) (day) (year)
(c) Cemetery or crematory Greene Cemetery
Location Belleview Ave

18 (a) Funeral director A. L. Ochs
(b) Address 4644 York, Pa.

19 (a) Sept 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 31 1945, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 45 to Aug. 31 19 45, and that I last saw h im alive on August 31 19 45.

Immediate cause of death	Duration
Cardiac hypertrophy and dilatation severe, right and left, with failure, cause	
Due to undetermined	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug. 21, 1945
Major findings of operation: Paracentesis thoracis
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 9/4/45

VS 180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3B

Registered No. 32115

32115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Lanvale
(c) Hospital or institution: Sarah Ann

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Rosa Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Clarence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1904.

8. AGE: Years	Months	Days	If less than one day
40	10	24	hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Raisin
13. Birthplace Burlington, N. J.

MOTHER
14. Maiden Name Blanche Waters
15. Birthplace Kent Co. Md.

16 (a) Informant Mrs. William Raisin
(b) Address 910 Sarah Ann St.

17 (a) Burial (b) Date thereof 9-4-'45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) SEP 5 1945 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 19 45 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 19 45 to Aug 31 19 45
and that I last saw h alive on 19
Immediate cause of death Pulm. TB

Duration
4 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 9-4-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32116

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓

Registered No. G32116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 Denison Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Denison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Curtis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie M.
nee Limon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-4-75

8. AGE: Years	Months	Days	If less than one day
70	9	28	hr. min.

9. Birthplace Kansas
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Curtis
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Mullen
15. Birthplace West Virginia

16 (a) Informant Miss Mary J. Curtis
(b) Address 713 Denison Street

17 (a) Burial (b) Date thereof 9/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3600 Old Frederick Rd.

18 (a) Funeral director Harry W. Witzke
(b) Address 3030 Edmondson Avenue

SEP 5 - 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1944, to Sept. 2, 1945 and that I last saw h. im alive on Sept. 1, 1945

Immediate cause of death Acute Cardiac Insufficiency — Duration

Due to Arteriosclerotic Cardio-vascular Disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kump
Address 3030 Edmondson Ave. Date signed 9/4/45

X

G32117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G32117 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont Ave & Edmondson Ave
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23da
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Merrittsville, Balto Co. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~August Sadosky~~ August Sadosky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Johanna Sadosky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1861

8. AGE: Years: 84 Months: 4 Days: 3 If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: Was retired.

11. Industry or business

FATHER
12. Name: Fredrick Sadosky
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Klaus
15. Birthplace: Germany

16 (a) Informant: Wm. E. Sadosky
(b) Address: Merrittsville, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory: TERRAINE-PARK
Location: Irvington, Md.

18 (a) Funeral director: C. Stappert & Son
(b) Address: 326 Eastern Ave

19 (Signature) SEP 5 - 1945 (Date rec'd by registrar) Huntingtown Md. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/45, at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12/45 to 9/2/45.
That I last saw him alive on 9/2/45.

Immediate cause of death: Heart + respiratory collapse.
Due to: Chr. debilitation, and long stay in bed
Due to: Bilateral neck fracture of femur.
Other Conditions:
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: 8-12-45 at M
(c) Where did injury occur? Merrittsville, Balto Co.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell down stairs inside home

23. Signature: Hayden E. Markham M.D.
Address: University Hosp. Date signed 9/2/45

Approved: Robert Lee Graham M.D.

VS 150

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM WESLEY MEEKS

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-07-8539

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Gertrude E. Meeks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1865

8. AGE: Years 79 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John W. Meeks
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Elizabeth Woolford
15. Birthplace Hanover, Pa.

16 (a) Informant Mr. Guy Wesley Meeks
(b) Address 819 N. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 5 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 3, 1945 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Sept 3 1943 and that I last saw h[illegible] alive on Aug 25 1945

Immediate cause of death — Duration

Coronary Thrombosis

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Armand L. French M. D.
Address 2379 Arunah St. Date signed 9/5/45

Vol. 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G32119 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Loyola Northway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 2414 Loyola Northway (If rural give location)
(e) Citizen of foreign country? Loyola (Yes or No)
If yes, name country

3 (a) FULL NAME Sheila Mindel Bereswurth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26-45

8. AGE: Years | Months 6 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Bernard Bereswurth
13. Birthplace Balto

MOTHER 14. Maiden Name Pearl Machtey
15. Birthplace Russia

16 (a) Informant Bernard Bereswurth
(b) Address 2414 Loyola Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)
(c) Cemetery or crematory Pikesville Memorial Park
Location

18 (a) Funeral director Jos. Levy and Son
(b) Address 1439 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

SEP 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-45 19 , at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 , to Sept 4 19 45, and that I last saw her alive on Sept 4 19 1945

Immediate cause of death Acute pneumonia — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Levy M. D.
Address 3804 W. Hyde Park Blvd Date signed 9-4-45

X X

G32120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G32120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 E. 21½ Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Ball (Young)

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Separated

6 (b) Name of husband or wife Stephen Ball

6 (c) If alive, give age x years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1915

8. AGE: Years	Months	Days	If less than one day: hr.	min.
29	8	8		

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Geo. T. Cummings
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Ellis
15. Birthplace Trinidad

16 (a) Informant Jessie Planter
(b) Address 770 Sarah Ann St

17 (a) Burial (b) Date thereof 9-6-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date per day registry) (b) Huntington Williams, M.D. Registrar

9-5-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1945 at 1 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shotgun wound of Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-45 1 A M.
(b) Where did injury occur? 706 Sarah Ann St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - shotgun

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-1-45

X

G32121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164 G32121

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Sarah ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen C. Ball

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Separated

6 (b) Name of husband or wife: Mildred Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1901

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	3	25		

9. Birthplace: White Stone, Va.
(Town, county, and state)
10. Usual Occupation: Contractor
11. Industry or business

FATHER
12. Name: George Ball
13. Birthplace: Va.

MOTHER
14. Maiden Name: Carrie Smith
15. Birthplace: Va.

16 (a) Informant: James B. Ball
(b) Address: 830 Bradley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location

18 (a) Funeral director: Adolphus Halstead
(b) Address: 918 Druid Hill Ave

19 (a) [illegible] (b)
(Date rec'd by registrar)
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1945, at 1:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shot gun wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-45 at 1 A.M.
(b) Where did injury occur? 706 Sarah ann St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Cause of injury: Firearm - shot gun
23. Signature: Howard J. Maddin M.D.
Medical Examiner.
Date signed 9-1-45

Waiting for [illegible]

X X

G32122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

G32122 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospl. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks.

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 727 W. Mulberry St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Naomi Berry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	Colored	Married

6 (b) Name of husband or wife Thomas Young Berry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [redacted] 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Richmond Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name John Brown

13. Birthplace Va.

MOTHER

14. Maiden Name Gabrita ?

15. Birthplace Va.

16 (a) Informant Elizabeth Williams

(b) Address 727 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cemetery

Location Mt. Winans Md.

18 (a) Funeral director Leonard Wheeler

(b) Address 1200 McCulloh

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1945, at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 19__, to 9/1 1945, and that I last saw h[illegible] alive on 9/1 1945

	Interval between onset and death
Immediate cause of death Bronchopneumonia Bilateral	2 days
Due to (Hypostatic pneumonia)	3 days
Due to	
Other Conditions Cerebral edema?	2 wks.

(Include pregnancy within 3 months of death)

Date of operation 8/ 1945

Major findings of operation: Myxoma of uterus

of autopsy: Bronchopneumonia Cerebral edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature T. T. Rundell

Address University Hospital Date signed 9/5/45 M. D.

G32123 G32123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 NORWOOD AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2937 DILLON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HOLZMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARGARET HOLZMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 4 1869

8. AGE: Years	Months	Days	If less than one day
76	3	29	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation MERCHANT
11. Industry or business FOR SELF

FATHER
12. Name UNKNOWN
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant HELEN MORAN (FOSTER DAUGHTER)
(b) Address 4709 NOEWOOD AVE.

17 (a) BURIAL (b) Date thereof SEPT. 6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) SEP 5 1945 (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1945, at 3 15 PM

21. I certify that I took charge of the remains described above, held an J + S thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic
C V - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Thuston M.D.
Medical Examiner.
Date signed 9/4/45

VS 151

X

G32124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32124

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 901 Stoll St (2s-)

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 901 Stoll St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth N. Howard

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank H Howard

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 11-1877

8. AGE: Years	Months	Days	If less than one day
68	-5	-24	hr. min.

9. Birthplace Newark N. J.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER

12. Name Rev. R. J. Holmes

13. Birthplace N. J.

MOTHER

14. Maiden Name Hanna J Buchanan

15. Birthplace unknown

16 (a) Informant Howard Sweeny

(b) Address 307 Lackawanna St Olyphant Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-45 (month) (day) (year)

(c) Cemetery or crematory Dunmore Cem

Location [redacted] Scranton Pa

18 (a) Funeral director Milton J Schilling

(b) Address 3914 N. Hanover St

19 (a) SEP 5 1945 Huntington Williams, M.D.

(b) Address 914 Baltimore Ave

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1945, to Sept. 4 1945, and that I last saw h.r alive on Sept 3 1945

Immediate cause of death	occlusion of coronary arteries	Duration
Due to	sclerosis of coronary arteries	several years
Due to	/	
Other Conditions	none	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. Howard M. D.

Address 914 Baltimore Ave Date signed 9-5-45

G32125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

G32125

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital, Balt. Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Otsego St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester B Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-22-0944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married.

6 (b) Name of husband or wife Clara Hays Kennedy
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 15 1883

8. AGE: Years	Months	Days	If less than one day
62	4	19	hr. min.

9. Birthplace Havre De Grace (Town, county, and state)
10. Usual Occupation Ret. Carpenter
11. Industry or business Penna RR Co

FATHER
12. Name George Kennedy
13. Birthplace Havre de Grace

MOTHER
14. Maiden Name Lethia Malsbe
15. Birthplace Penna

16 (a) Informant Clara Hays Kennedy
(b) Address 840 Otsego St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7 1945 (month) (day) (year)
(c) Cemetery or crematory Angel Hill Cem
Location Havre de Grace Md

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

19 (a) SEP 5 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1945, at 2 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945 to Sept. 4 1945 and that I last saw h[illegible] alive on Sept 4, 1945

Duration

Immediate cause of death Coronary occlusion
Due to Ca of colon ruptured
Due to multiple pulmonary emboli
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ca colon ruptured and perforated

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George R. Callender M. D.
Address Univ. Hospital - Balt Date signed 9-4-45

VS 150

G32126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1712

Registered No. G32126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1142 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Paige

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Carrie Terry Paige

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-1899

8. AGE: Years	Months	Days	If less than one day
46	5	1	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alex Paige
13. Birthplace N. C.

MOTHER
14. Maiden Name Julia Richa
15. Birthplace Va

16 (a) Informant Carrie Terry Paige
(b) Address 1601 Abbott St

17 (a) Shipped (b) Date thereof 9-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Churchland Cem
Location Churchland City. Virginia

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) SEP 5 - 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945, at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Rupture of Liver

Due to

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-2-45 at 3:30 P.M.
(b) Where did injury occur? Gilmore St. and Riggs Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by street car

23. Signature Robert Lee Fiddler M.D.
Medical Examiner.
Date signed Sept 3 1945

VS 151

Huntington Williams, M.D.

G32127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1554 Carswell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1554 Carswell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel C. Muir Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Muir

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/8/83

8. AGE: Years 62 Months 6 Days 27 If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Self employed

FATHER 12. Name James Muir

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden Name Catharine Cowan

MOTHER 15. Birthplace Scotland

16 (a) Informant Mrs. D.C. Muir Sr.

(b) Address 1554 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 7 45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md

18 (a) Funeral director Carnahan Funeral Home

Address 2401 Belair Rd

19 (a) SEP 5 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4th 1945; at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Sept 4 1945, and that I last saw him alive on Sept 3 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 yrs
Due to Hypocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward C. Zimmerman, M.D.

Address 2858 Harford Rd Date signed 9-7-45

Washington Hollerman, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

M. D. B. 1000-9

G32128 ✓ G32128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 97

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4415 Powell Avenue St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Alice Virginia Askew

(a) Residence: No. 4415 Powell Avenue St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) April 24, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	4	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Benjamin German

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Georgianna Clark

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mr. Clifton R. Askew
(Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Baltimore Cem. Date 9/8/45 19

19. UNDERTAKER HENRY SANDER & SONS, INC.
(Address) NORTH AVE. & BROADWAY

20. FILED SEP 5 - 1945 19 Huntington Willis Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 3, 1945

22. I HEREBY CERTIFY, That I attended deceased from August 20, 1945 to Sept 3, 1945

I last saw her alive on Sept 2, 1945 Death is said to have occurred on the date stated above, at 2:30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Edema	

Other contributory causes of importance:

Senility	—
Arteriosclerosis	—
Hypertension	—

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Fred E Hudson M. D.

(Address) 4415 Powell Ave

OCCUPATION is very important. See instructions on back of certificate. U. S. ...

G32129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1372

G32129 Registered No.

The information requested on this certificate is necessary for the registration of the death. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Overland ave.
(c) Hospital or institution: University Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Overland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. William Hartman Kable

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

Maggie Lee [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June [illegible], 1869

8. AGE: Years 78 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Dr. Now retired.

11. Industry or business

FATHER 12. Name John Hartman Kable

13. Birthplace W. Va

MOTHER 14. Maiden Name Eleanor Dudrow

15. Birthplace Frederick Co. Md.

16 (a) Informant Mrs. Gertrude K. Harrison

(b) Address 2910 Overland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Baltimore, Maryland

18 (a) Funeral director H. SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by Registrar) SEP 5 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1945 at 5.53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1945 to 9/4 1945, and that I last saw him alive on 5.53 P.M. 1945

Immediate cause of death	Duration
Respir atory failure.	
Due to Uremia.	
Due to B. Coli septicemia.	
Other Conditions Chr. debilitation.	

(Include pregnancy within 3 months of death)

Date of operation 8/27

Major findings of operation: Benign pros. by autopsy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradshaw M. D.

Address Date signed

VS 150

Huntington Williams, Mgr.

X

G32130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G32130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 N. Milton Avenue
(c) Hospital or institution St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Fritzges

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	219-05-9488	M	W	Married

6 (b) Name of husband or wife Lola Fritzges
6 (c) If alive, give age 188 years
7. Birth date of deceased (mo., day, yr.) Nov. 7, [illegible]

8. AGE: Years	Months	Days	If less than one day
~~Mos~~ 55	9	~~28~~ 29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Cigar Business
11. Industry or business

FATHER
12. Name Charles Fritzges
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Dora Seabach
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Lola Fritzges
(b) Address 1424 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address 3E NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/4/45

VS 151

G32131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1702

G32131

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 Curlew Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria J. Milton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-1944

8. AGE: Years	Months	Days	If less than one day
	11	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Willie E. Milton
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Harrell
15. Birthplace N. C.

16 (a) Informant Willie E. Milton
(b) Address 236 Curlew St.

17 (a) Burial (b) Date thereof 9/6/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Presstman St.

19 (a) SEP 5 1945 Huntington Williams
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1945 at 1730 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/3/45 at 925 P. M. B. Loc.
(b) Where did injury occur? Dundalk Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury: Passenger in auto collision
Signature Robert A. Gaston M.D.
Medical Examiner.
Date signed Sept 4 1945

VS 151

G32132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32132

Registered No. 134a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 Gough St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Gough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Donoho

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-2894

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna L. nee Sauer
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1885

8. AGE: Years	Months	Days	If less than one day
60	7	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Marine Supt.
11. Industry or business

MOTHER / FATHER
12. Name Frank
13. Birthplace Md.
14. Maiden Name Katherine Goodwin
15. Birthplace Ireland

16 (a) Informant Anna L. Donoho
(b) Address 2016 Gough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

SEP 5 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1945 at 12:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan. 1935 to Sept. 1 1945 and that I last saw him alive on Aug. 31 1945

Immediate cause of death: Acute Coronary occlusion — Duration 1 day
Due to Coronary Heart Disease — 14 yr.
Due to
Other Conditions Hypertension ?
& Cystitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. F. Hoffmann
Address 200 N. Gay Date signed 9/1/45 D.

VS 180

Sept 2 1945 Hartford.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

G32133 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3411

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1907

8. AGE: Years	Months	Days	If less than one day
37	9	6	hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)

10. Usual Occupation Oil Burner Machinist

11. Industry or business

FATHER
12. Name William W. Wilson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Julia May Rochester
15. Birthplace Balto. Md.

16 (a) Informant Julia May Wilson
(b) Address 2127 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) Filed SEP 3 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1945, to Sept 2 1945, and that I last saw h[illegible] alive on Sept 2 1945

Immediate cause of death	Duration
Uremia Requiring Hemodialysis	7 d.
Due to Arterio Sclerosis Hypertension	10 Y.
Due to Carcinoma Pancreas with Metastasis	1 M.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. A. Stevens, M.D.
Address 2818 Hartford Ave Date signed 9/3/45

VS 190

G32134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

333a

Registered No. G32134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 Mc Elderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Callie Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Porter Taylor
13. Birthplace S. C.

MOTHER
14. Maiden Name Julia
15. Birthplace S. C.

16 (a) Informant Samuel Coleman
(b) Address 1627 Mc Elderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Bentley

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1945 to 9-1 1945, and that I last saw h alive on 9-1 1945.

Immediate cause of death: Bronchopneumonia — Duration 8 days

Due to Hypostatic Pneumonia

Due to Chills & Exposure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake, M.D.
Address 527 N. Central Ave. Date signed 9/1/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G32135

JO #94201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G32135

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Penn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Elizabeth Flowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife John (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. ?, 1875

8. AGE: Years	Months	Days	If less than one day
70	6 ?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clem Ford (d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Young (d)
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave. Huntingtown Mt. Hamme, Md.

SEP 5 1945 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1945 at 4:50P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15, 1945, to Sept. 1, 1945, and that I last saw her alive on Sept. 1, 1945.

Immediate cause of death	Duration
Coronary Occlusion	May
Due to Hypertension Cardio Vascular Disease	?
Due to	
Other Conditions Fracture rt. femur	5 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence April 1945
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury Fell down at home.

23. Signature Hercule E. Belton

Address Baltimore City Date signed 9/5/45

VS 150

SUBJECT TO APPROVAL OF MEDICAL EXAMINER:

Hosp. referred: Dept of Charities

G32136 Foreman G32136

BALTIMORE CITY HEALTH DEPARTMENT Registered No. 1318

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 S. Sharp St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 S Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Aug - 24 - 1898

8. AGE: Years	Months	Days	If less than one day
47	—	11	hr. min.

9. Birthplace Hanover Va
(Town, county, and state)

10. Usual Occupation Laborer Shipping Dept

11. Industry or business Paper Co

FATHER
12. Name Thomas Freeman
13. Birthplace Unknown Va

MOTHER
14. Maiden Name Margaret
15. Birthplace Virginia

16 (a) Informant Lillian Freeman
(b) Address 1234 S. Sharp St

17 (a) Burial (b) Date thereof Sept 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A.Co Md.

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Montgomery Street

(a) Registered (Registrar) Huntington Williams Registrar

SEP 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1945, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 1945 to Sept 4 1945 and that I last saw him alive on Sept 2 1945

Immediate cause of death	Duration
Myocarditis	
Due to Chronic nephritis	
Due to	
Other Conditions Hypertension Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Freeman M. D.
Address 1744 W. Lee Date signed 9/4/45

VS 150

X

G32137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G32137

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 W Hughes St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Leroy Hillery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14 1930

8. AGE: Years	Months	Days	If less than one day
14	10	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER
12. Name Howard Hillery
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Carrie Coleman
15. Birthplace Baltimore Md

16 (a) Informant Carrie Hillery
(b) Address 1340 W Hughes Street

17 (a) Burial (b) Date thereof Sept 5 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory A.A. Co. Md
Location Mt Calvary Cem

18 (a) Funeral director Sarah R Brown Son
(b) Address 108 W Montgomery Street

SEP 5 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945, at 2 P M

21. I certify that I took charge of the remains described above, held an Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 24/4

(a) Date of injury September 1945 M.
(b) Where did injury occur Harbor at Williams St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning

23. Signature Robert Lee Waters M.D.
Medical Examiner.
Date signed 9-2-45

G32138 G32138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) *
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife Clara Wood
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown - 1879

8. AGE: Years	Months	Days	If less than one day
66(?)		—	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George
13. Birthplace Va.

MOTHER
14. Maiden Name Anderson
15. Birthplace Va.

16 (a) Informant Mrs Walter Smith
(b) Address 702 W. Fayette St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location 3801 Greenmount Ave
18 (a) Funeral director Wm. J. Cowan Son
(b) Address 901 Eutaw St.
19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

SEP 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 3 1945 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1945 to 9-3 1945 and that I last saw h[illegible] alive on 9-2 1945

Immediate cause of death	Duration
Cong. Failure	
Due to Hypertension Cardiff. vascular disease	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark, M.D.
Address University Hosp. Date signed 9-3-45

X

G32139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered G32139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Walther Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Walther Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lieut. Theodore R. Mueller

3 (b) If veteran, name war World War #1

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie M. Mueller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 - 1892

8. AGE: Years 53 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Balto. Police Dept.

11. Industry or business

FATHER
12. Name Robert Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Amyl Fink
15. Birthplace Germany

16 (a) Informant Marie M. Mueller
(b) Address 5301 Walther Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 8 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip H. Feury Sons
(b) Address 2024 Orleans St

19 (a) (Date received by registrar) (b) Registrar
SEP 5 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1945 at 1 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 29 1945, to Sept 5 1945 and that I last saw him alive on Sept. 3 1945.

Immediate cause of death Cardiac failure
Coronary thrombosis

Due to Arteriosclerosis of coronary arteries

Due to

Other Conditions Hypertension
? Pulmonary infarct.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 wk

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard N. Tillman MD M. D.
Address 3036 St. Paul St Date signed Sept 5th

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE BLACK INK. Every item of information should be carefully supplied. The

G32140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32140

Registered No. 63262

1246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State District of Columbia (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Ridge Pl. S. E.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Erlin Eretta Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married-Sep.

6 (b) Name of husband or wife Francis Edward Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1908

8. AGE: Years	Months	Days	If less than one day
37	2	16	hr. min.

9. Birthplace Greenville, Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Dull
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Jane Huntley
15. Birthplace Virginia

16 (a) Informant Records - U.S. Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8th 1945 (month) (day) (year)
(c) Cemetery or crematory Staunton Va.
Location

18 (a) Funeral director Diff Bros
(b) Address 3109 Fredk Ave.

19 (a) Sep 5 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH September 4 1945, at 3:57 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 1945, to Sept 4 1945, and that I last saw her alive on Aug 4 1945.

Immediate cause of death Portal cirrhosis — Duration 2 months
Acute hepatitis due to unknown cause.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U.S. Marine Hospital Date signed 9/5/45

VS 150

Please see that every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G32141

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Millers
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George D Lippy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E Carr
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) Oct 12-1905

8. AGE: Years	Months	Days	If less than one day
39	10	22	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name George W Lippy
13. Birthplace Maryland

MOTHER
14. Maiden Name Hattie H Hale
15. Birthplace Maryland

16 (a) Informant Mrs Geo D Lippy
(b) Address Millers Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Pleasantville
Location Balto Md

18 (a) Funeral director Edw Clapton
(b) Address Upperco Md

19 (a) 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1945, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquest & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-2-45 at P. M.
(b) Where did injury occur? Millers, Carroll Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Thrown from horse

23. Signature Robert L Grafton M.D.
Medical Examiner.
Date signed Sept 5 1945

VS 151

G32142

G32142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Baltimore 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Fairview Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME MRS ANNA E MARLOW

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~of wife~~ ALBERT H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 26-1875

8. AGE: Years	Months	Days	If less than one day
70	7	9	hr. min.

9. Birthplace Easton, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jesse Shannahan
13. Birthplace MD.

MOTHER
14. Maiden Name ANNA EATON
15. Birthplace MD

16 (a) Informant Albert H. Marlow
(b) Address 3704 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave Md

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945, to Sept 4 1945, and that I last saw h[illegible] alive on Sept 3 1945.

Immediate cause of death Insurance Cerebral Hemorrhage — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips
Address Md. Gen. Hosp. Date signed 9/4/45

VS 8

G32143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1645

G32143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 734 South Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter W. Scarboro

3 (b) If veteran, name war

3 (c) Social Security Account No. ~~Non~~ None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Vivian Pearl Scarboro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1904

8. AGE: Years 41 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Charleston W. Va. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name William Scarbro

13. Birthplace Jackson Co W. Va.

MOTHER 14. Maiden Name Mary F. Goode

15. Birthplace W. Va.

16 (a) Informant Wife Vivian Scarbro

(b) Address 1841 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)

(c) Cemetery or crematory Spring Hill

Location Charleston W. Va.

18 (a) Funeral director Frank V. Papitone

(b) Address 251 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 131

MEDICAL CERTIFICATION 25

20. DATE OF DEATH September 5 1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Deep Laceration

J Neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-5-45 at 8:45 P. M.

(b) Where did injury occur? 934 S. Bond Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Razor

23. Signature Richard A. Fontana M.D. Medical Examiner.

Date signed Sept 5 1945

Sept 5 1945

X

D G32144 2-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G32144 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 N. Dallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 527 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebbecca Perry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Ann Arundle Co. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Ellen Bennett
(b) Address 527 N. Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)

(c) Cemetery or crematory
Location Meadowridge, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Lane Huntingtown, Md.

19 (a) (Date received by registrar) Registrar

SEP 5 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/45 September 1945 at 5:30 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 16 1945, to Sept 1 1945, and that I last saw h alive on 19

Immediate cause of death	Duration
Bronchopneumonia	1 week
Due to Senility	
Due to Cerebral Hemorrhage	
Other Conditions Gleason Bowelling Hemo	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Lefurgy M. D.
Address 622 N. Bond Date signed 9/1/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The exact time of death and any other information should be carefully supplied.

G32145

BALTIMORE CITY HEALTH DEPARTMENT ✓ G32145

CERTIFICATE OF DEATH

Registered No. 186a

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Eastern & 33rd
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 576 Beaumont (If rural give location)
(e) Citizen of foreign country? Z (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M. DIEDEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-8851

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella C Diedeman

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Apr 26 1880

8. AGE: Years	Months	Days	If less than one day
65	4	7	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business U S For. S. Co

FATHER
12. Name Henry Diedeman
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Gottlieb
15. Birthplace Germany

16 (a) Informant Ella C Diedeman
(b) Address 576 Beaumont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eastern Ave

19 (a) 1045 (b) Filed by registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/45 19 ____, at 4:12 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH. Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/3/45 at 3:30 P 27/10 M.
(b) Where did injury occur? 546 Beaumont
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Fell from 2nd floor window

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 9/3/45

(over)

G32146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G32146

Registered No. 14716

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 23 days
(e) Length of stay in Baltimore (yrs., mos., or days): 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2702 Presbury Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Carlyle Alpheus Graham

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Irene A. Graham
6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1891

8. AGE: Years	Months	Days	If less than one day
53	8	24	..... hr. ..... min.

9. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual Occupation: Watchman
11. Industry or business: Seafaring

FATHER
12. Name: Frank Graham
13. Birthplace: Pennsylvania

MOTHER
14. Maiden Name: Ida Summers
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Records - U. S. Marine Hosp
(b) Address: Baltimore, Maryland.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: 5501 Frederick Rd
18 (a) Funeral director: E. Watzke
(b) Address: 4901 Edmondson Ave
19 (a) 1945 (b) ..... Registrar
Date received by registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: September 2 1945, at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1945, to Sept. 2 1945, and that I last saw him alive on September 2 1945.

Immediate cause of death	Duration
Cancer of bladder with abdominal and pulmonary metastasis	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson M. D.
Address: U. S. Marine Hospital Date signed 9/5/45

VS 150

Physicians: please write the causes of death clearly and legibly. The

G32147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G32147

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gilbert
(c) Hospital or institution:
Union Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Penn Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Scott — ELANIE SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1945

8. AGE: Years | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Haskins
15. Birthplace Va.

16 (a) Informant Mrs. Louise Scott
(b) Address 9 Penn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 SEP 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/45 1945, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945 to 9/2 1945, and that I last saw h[illegible] alive on 9/2 1945.

Immediate cause of death Dehydration, cardiac

Due to Diarrhoea

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Kmak MD M. D.

Address Union Hosp. Date signed 9/5/45

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G32148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1dy.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 135 Eaton alley (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Clark

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter Clark
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Johnson
15. Birthplace Va.

16 (a) Informant Mrs. Mary Bond
(b) Address 505 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Levy Cem.
Location Greenbay, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St. Huntington Williamsburg

19 (a) (Signature of registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 8:58 P.M.

21. I certify that death occurred on the date above-stated; that I attended deceased from Sept 3 1945, to Sept 4 1945, and that I last saw h[illegible] alive on Sept 4 1945.

Immediate cause of death	Duration
Pneumonia Surgery Unproved on TB a	5 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Lung abscess & Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dudley Dudley, M.D.
Address Md. General Hosp. Date signed 9/5/45

Sept 6 VSJ

X

G32149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 ✓

G32149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Poplar Terrace (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Alice Gildea Bittle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife R. H. Bittle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1855.

8. AGE: Years	Months	Days	If less than one day
90	1	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John H. Gildea
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachael Hunter
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Ralph G. Bittle
(b) Address 706 Stoneleigh Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) [illegible] (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1945, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 3 1945, and that I last saw h[illegible] alive on Sept 3 1945

Immediate cause of death	Duration
Coronary thrombosis	2 days
Due to Generalized sclerosis	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas F. Kelemen M.D.
Address 6 East Biddle St Date signed 9/6/1945

SEP 6 1945 Huntington Williams M.D.

6 E BIDDLE

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32150

SLUZEWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32150

120a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give County)
(d) Street No. 2315 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Sluzewski

3 (b) If veteran, name war

3 (c) Social Security Account No. has none

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Sluzewski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Agnes Przybylski
15. Birthplace Baltimore

16 (a) Informant Josephine Sluzewski
(b) Address 2315 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Wagazewski
(b) Address 1930 Eastern Ave.

19 (a) SEP 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1945 at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-5-45

VS 151

G32151 FAULKNER ✓ G32151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 30 a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N Calvert
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Calvert St (If rural give location)
(e) Citizen of foreign country? Calvert (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-7429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Charles Faulkner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-11-1884

8. AGE: Years	Months	Days	If less than one day
60 61	9	22	hr. min.

9. Birthplace Lancaster Co. S. C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Lewis Faulkner
13. Birthplace Lancaster Co. S. C.

MOTHER
14. Maiden Name Amanda Crawford
15. Birthplace Lancaster Co. S. C.

16 (a) Informant Alice Faulkner
(b) Address 400 N. Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Jason Cem
Location

18 (a) Funeral director Mrs Geo. Hall
(b) Address 1611 Druid Hill Ave

19 SEP 6 - 1945 Registered by Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1945 at 12 50 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 30 1945 to Sept 3 1945, and that I last saw h[illegible] alive on Sept 3 1945.

Immediate cause of death Cerebral hemorrhage — Duration 6 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 75 [illegible] Date signed 9/6/45

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any error or omission should be carefully supplied. The

VS 150

6-32152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 6-32152

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Pkwy
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Eloise Featherston Dale

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Col. Frederick A. Dale

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) Feb 4 1879

8. AGE: Years 66 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Holly Springs, Miss.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Winfield F. Featherston

13. Birthplace ?

MOTHER 14. Maiden Name Elizabeth McEwen

15. Birthplace ?

16 (a) Informant Charles Rowland Posey

(b) Address 617 W. University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons

(b) Address McCulloh & Orchard Sts.

19 SEP 6 - 1945 (Date rec'd by registrar) Printing for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1945 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 4 1945.
and that I last saw h— alive on Sept 4 1945.

Immediate cause of death: Cerebral Vascular accident — Duration 1 hour

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Francis W. Gluck, M.D.
Address 715 Park Ave. Date signed 9/5/45

VS 150

632153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 M

Registered No. 632153

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Braddish Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Braddish Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Carrie Olee Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John Joseph Smith
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec-16-1883

8. AGE: Years 61 | Months 8 | Days 16 | If less than one day: hr. min.

9. Birthplace Winchester, Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Ernest Hepting
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Engle
15. Birthplace Virginia

16 (a) Informant Mr. Harry W. Bauer (son-in-law)
(b) Address 1620 Braddish Avenue, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-7-1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Avenue, City.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue, City.

SEP 6 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1945 at 9.38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1945 to September 1945, and that I last saw h[illegible] alive on September 4 1945.

Immediate cause of death
Carcinoma of L. I. Jaw
c Generalized metastasis — Duration 1 yr!
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leon Coleman M. D.
Address 1201 Eutaw Place Date signed 9-5-45

VS 180

X

632154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 632154

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colored St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. Ellingham Road (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Emma C. Morgan (EMMA Eugenia Morgan)

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife Clinton Gerard Morgan

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1867

8. AGE: Years 77 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry M. Roane
13. Birthplace Virginia

MOTHER
14. Maiden Name ? Triggs (Estelle Trigg)
15. Birthplace Virginia MD.

16 (a) Informant C. Gerard Morgan, Jr. (Son)
(b) Address Ruxton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 106 W. NORTH AVENUE

SEP 6 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1945; at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945, to 9/4 1945, and that I last saw her alive on 9/4 1945.

Immediate cause of death: Terminal pneumonia — Duration 9 days
Due to: Cerebral vascular accident
Due to: Hypertensive cardiovascular disease
Other Conditions: Carcinoma of Colon
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Youngstrom Jr. M. D.
Address 352 E. Lanvale St. Date signed 9/4/45

VS 180

G32155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. VA 14726

G32155

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3834 Cottage Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Schwartzman

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida Schwartzman
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1892

8. AGE: Years	Months	Days	If less than one day
53	7	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Telephone operator
11. Industry or business

FATHER
12. Name Baer Schwartzman
13. Birthplace Russia

MOTHER
14. Maiden Name Toba Levine
15. Birthplace Russia

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore County

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Pratt St.

19 SEP 6 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1945, at 8:17 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1945, to Sept. 5, 1945, and that I last saw him alive on Sept. 5, 1945.

Immediate cause of death	Duration
Carcinoma of head of the pancreas with biliary obstruction	6 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None done
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S R Baker M. D.
Address U.S. Marine Hosp Date signed 9/5/45

VS 150

G32156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G32156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Da
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3376 Virginia Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Shanfeld

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-01-7986

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation French Work
11. Industry or business Navy Oil Burner

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Ruby Shanfeld
(b) Address 3376 Va. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Rosefield
Location

18 (a) Funeral director Pace Home Inc
(b) Address 1739 Eutaw St

SEP 6 - 1945 (Date rec'd by Registrar) (Signature for Williams)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6/45, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 9/6/45

G32157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G32157

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 739 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA D. CASCIERO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: Geramia Casciero
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1894

8. AGE: Years	Months	Days	If less than one day
51 yrs.	2	3	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ciciaco Scogna
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Nicola DiTiero
15. Birthplace Italy

16 (a) Informant Geramia Casciero (husband)
(b) Address 739 N. Milton Avenue

17 (a) Burial (b) Date thereof 9/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Annapolis, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

(c) Filed SEP 6 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1945, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1945 to 9-4 1945, and that I last saw her alive on 9-3 1945.

Immediate cause of death ?	Duration
Due to Carcinoma of ovary	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley R. Steinbach M. D.
Address Sinai Hospital Date signed 9-4-45

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32158 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY GRACE ASHLEY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1864

8. AGE: Years 80 | Months 11 10 | Days 0 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William McDaniel
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Collins
15. Birthplace Virginia

16 (a) Informant Mr. Layton Ashley
(b) Address 142 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 6 1945 (b) Registrar Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH sept. 3, 1945, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 5 1945 to Sept 3 1945, and that I last saw h[er] alive on Sept 3 1945

Immediate cause of death Hypertension Cardio Vascular Renal

Due to Endocarditis

Due to Nephritis

Other Conditions Arterio-Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. John G. Duncan M. D.

Address 26 E. Preston St Date signed Sept 4 1945

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45 F

G32159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 Forrest St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 Forrest St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17th 1870

8. AGE: Years 75 Months 4 Days 17 If less than one day hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Hankins

13. Birthplace Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace " "

16 (a) Informant Annie Miles

(b) Address 1015 Niagara St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7th 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md.

18 (a) Funeral director Benjamin Maurice H. Wright

(b) Address 724 Edgewood St

19 (a) SEP 6 1945 Huntington Miller

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 1945, and that I last saw h.r alive on Aug 28 1945

Immediate cause of death Acute dilitation of heart. — Duration 3 yrs.

Due to Carcinoma of Pharynx.

Due to Metastasis of lungs. Metastasis

Other Conditions Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert E. Burwell

Address 121 Aisquith Date signed 9/5/45 M.D.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G32160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Belmore Court
(If rural, give location)
(e) Citizen of foreign country? Baltimore (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Rankins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife Lorie Rankins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2d 1890

8. AGE: Years	Months	Days	If less than one day
55	1	11	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Rankins
13. Birthplace N. C.

MOTHER
14. Maiden Name ~~Beulah Hall~~
15. Birthplace ~~1629 Belmont Ct.~~

16 (a) Informant Beulah Hall
(b) Address 1629 Belmont Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 6 - 1945 (Date rec'd by registrar) ~~Huntington Williams, M.D.~~

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1945 at 12 a. M 35

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiovascular-renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 9-5-45

VS 151

G32161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G32161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Mullin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Farrell Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1945

8. AGE: Years	Months	Days	If less than one day
	5		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Farrell Jr.
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Md.

16 (a) Informant Sarah Farrell Jr.
(b) Address 1808 Mullin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Presstman St

19 SEP 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1945 at 6 20 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Medicus M.D.
Medical Examiner.
Date signed 9-5-45

VS 151

G32162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G32162
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Glenwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh E Lomus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 1945

8. AGE: Years	Months	Days	If less than one day
		2 days	hr. min.

9. Birthplace Glenwood Howard County
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Lyle Lomus
13. Birthplace Penna

MOTHER
14. Maiden Name Ethel Hopkins
15. Birthplace Va

16 (a) Informant Lyle Lomus
(b) Address Glenwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 1945 (month) (day) (year)
(c) Cemetery or crematory Lotsville Mem
Location Montgomery Co.

18 (a) Funeral director Ralph W Barber
(b) Address Gaithersburg Md

19 (a) [illegible] (Filed by registrar) (b) Registrar

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1945 at 3.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1945 to Sept 5 1945 and that I last saw him alive on Sept 5 1945

Immediate cause of death Respiratory failure — Duration 2 hrs.
Due to Atelectasis — 24 hrs.
Due to Prematurity
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Streeter M. D.
Address Union Memorial Hosp Date signed 9-5-45

X

G32163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120a

G32163

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 N. Robenson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Robenson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bronislawa (Blanche) Boora

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nicifor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1893

8. AGE: Years 52 | Months 3 | Days | If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Zelinski
13. Birthplace: Poland

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Stella Malin
(b) Address: 606 N. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem.
Location: Wilmington Del.

18 (a) Funeral director: John J. Duda
(b) Address: 2829 Addison St.

19 (a) SEP 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1945, at 9 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Gastro-enteritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 9-6-45

VS 151

G32164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1579

G32164 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 90 Avalon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard T. Huelmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1945

8. AGE: Years	Months	Days	If less than one day
	6	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul M. Huelmer
13. Birthplace Ohio

MOTHER
14. Maiden Name Ruby Gibbs
15. Birthplace Peru.

16 (a) Informant Paul M. Huelmer
(b) Address 90 Avalon Ave Dundalk

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-45 (month) (day) (year)
(c) Cemetery or crematory St. Barnabas
Location Carrollton Pa. Cambria Co.

18 (a) Funeral director John H Connelly.
(b) Address 419 Eastern ave. Essex 21 Md.

19 (a) SEP 6 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 1:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hirschsprung's Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D. Medical Examiner.
Date signed Sept 6 1945

VS 151

G32165

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 127a

Registered No. G32165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and Saratoga
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County [redacted]
(c) City or town [redacted] Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 [redacted] Fricker St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME (Jennie Wood) EVA JANNIE Wood

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Enoch Wood

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept 10 1880

8. AGE: Years 64 | Months 11 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Frank Stinnett
13. Birthplace Maryland

MOTHER
14. Name [redacted] Wood
15. Birthplace Maryland

16 (a) Informant Enoch E. Wood
(b) Address 514 Hillburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8-1945 (month) (day) (year)
(c) Cemetery or crematory Mozanne Church Cem
Location Prime Frederick Md

18 (a) Funeral director Pratt C. B. M. Walford
(b) Address Pratt & Stricker St

SEP 6 - 1945 (Date rec'd by registrar) (b) Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6/45 19 , at 2.55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945 to 9/6 1945 and that I last saw her alive on 9/6 1945.

Immediate cause of death Peritonitis — Duration 2 days
Bile, Post Op.

Due to Operation Cholecysto- [redacted] duodenostomy

Due to Chronic Cholecystitis & obstruction — 25 yrs

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 9/6/45

Major findings of operation: Chronic Cholecystitis & obstruction

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex P. Talley Jr M.D.
Address Mercy Hosp Date signed 9/6/45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32166

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32166 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. N. Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Vineholt, Baby Boy.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: none
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9-5-45

8. AGE: Years | Months | Days | If less than one day: 14 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Oscar Vineholt
13. Birthplace Maryland

MOTHER
14. Maiden Name Thelma Monuel
15. Birthplace Virginia

16 (a) Informant Mrs. Oscar Vineholt
(b) Address 1327 Forest Rd. Balto. Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-7-45. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Jesus
Location Gorsuch Hill Rd. Balto.

18 (a) Funeral director J. Pleasants O'Donnell
(b) Address 32 S. Broadway

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 6 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1945, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1945 to 9-5 1945 and that I last saw him alive on 9-5 1945

Immediate cause of death: Respiratory failure. — Duration:

Due to: Aspiration of meconium

Due to:

Other Conditions: Atelectasis Premature Birth

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Stanley M. D.
Address Church Home + Hosp. Date signed 9-6-45

X

G32167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G32167 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Rokety Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4601 Rokety Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Hahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nora Post Hahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1899

8. AGE: Years	Months	Days	If less than one day
46	4 5	30 0	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Supt.
11. Industry or business B. V. D. Corp.

FATHER
12. Name Adam J. Hahn
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Glaus
15. Birthplace Germany

16 (a) Informant Mrs Nora Hahn
(b) Address 4601 Rokety Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Balto. Md.

18 (a) Funeral director Harry F. Wiseke
(b) Address 41016 Edmondson Ave.

19 (a) 9/6/1945 (Date registered) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1945, at 12 05 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 9/4/45

VS 151

G32168 G32168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEFFY, John M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MRS. EMMA R. Eckenrode

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10, 1857

8. AGE: Years	Months	Days	If less than one day
87	8	26	hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Martin Steffy
13. Birthplace Penna.

MOTHER
14. Maiden Name —
15. Birthplace Penna.

16 (a) Informant Mrs Emma Steffy
(b) Address 3720 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3500 W. Fredrick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. Sept 6 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945 to 9/6 1945, and that I last saw h[illegible] alive on 9/6/45 19

Immediate cause of death	Duration
Cardiac Respiratory failure	
Due to Hypostatic Pneumonia as a Complication of Operation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation August 30 1945

Major findings of operation: [illegible] Inguinal hernia & perforation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Bowe

Address Univ. Hosp. Date signed 9/6/45

X

G32169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

G32169

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 N. Calvert Street
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 939 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Unknown

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1893

AGE	Years	Months	Days	If less than one day
About 52				hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director R. Lee Adler
(b) Address 1616 Huntington Ave. Balto.

19 (a) SEP 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1945, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-31-45 at 11 A.M.
(b) Where did injury occur? 939 N. Calvert Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Unlit gas on gas range.

23. Signature Howard J. Anderson M.D. Medical Examiner.
Date signed August 31, 1945.

VS 151

G32170

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32170
Registered No.

X 122a

The correct answer to each item of information should be carefully supplied. The accuracy of each item is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oates & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Maple Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma C. Dobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Roy Penn Dobson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 9, 1871

8. AGE: Years: 73 | Months: 11 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Lawrence L. LeGourd
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Sarah Catherine Small
15. Birthplace: Maryland

16 (a) Informant: Mrs. Ross P. Cooper
(b) Address: Maple & Arbutus Ave., Halethorpe, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 8, 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Miller & Lamonaco
(b) Address: 4510 Liberty Heights Ave.

19 (a) SEP 6 - 1945 (Date rec'd by registrar)
(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/5 19 45 at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1945 to 9/5 1945
and that I last saw h alive on 9/4 1945

Immediate cause of death: Cardiac failure (acute)

Due to: Intestinal obstruction

Due to: Strangulated femoral hernia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jose A. Olivares de Chaudens
Address: St. Agnes Hospt Date signed 9/5/45 M. D.

VS 180

G32171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32171

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Pope

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1880

8. AGE: Years	Months	Days	If less than one day
64	10	5	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Linotype operator
11. Industry or business Sun Papers

FATHER
12. Name William F. Pope
13. Birthplace Florida

MOTHER
14. Maiden Name Mattie King
15. Birthplace Florida

16 (a) Informant Artemus W. Pope
(b) Address 23 Bayview St - St. Augustine Fla.

17 (a) Burial (b) Date thereof 9/7/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address SEP 7 - 1945 St. Paul St.
(Date rec'd by registrar)

19 (a) (b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1945, at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1945, to 9/5 1945, and that I last saw him alive on 9/5 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	8/27 - 9/5/45
Due to Acute Anterior Infarction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.A. Bailey M. D.
Address Mercy Hospital Date signed 9/6/45

VS 150

X

G32172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G32172

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia E. Bennett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 6th 1874

8. AGE: Years	Months	Days	If less than one day
70	11	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George L. Bennett
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lydia C. Ridgeway
15. Birthplace Balto. Md.

16 (a) Informant Francis Bennett
(b) Address 502 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 SEP 7 - 1945 (Date rec'd by registrar) (b) Huntington Nitt[illegible], M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/45 19 to 9-5 1945, and that I last saw h[illegible] alive on 9/5 1945

Immediate cause of death: Acute cardiac dilatation — Duration 1 hr.
Due to: Chronic myocarditis — Duration 3 yrs
Due to: Hypertension
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Pasis M. D.
Address 47 Fulton Date signed

VS 150

G32173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G32173 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 N. Appleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Coale

3 (b) If veteran, name war: 11

3 (c) Social Security Account No. 214-16-6816A

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Margaret Coale

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15th 1870

8. AGE: Years	Months	Days	If less than one day
74	9	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Building

FATHER
12. Name Lewis Coale
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Henrietta Gwynn
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Louise Smith
(b) Address 901 N. Appleton St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/7/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 7 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4th 1945 at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1944 to Sept 4 1945, and that I last saw h. im alive on Sept 3 1945.

Immediate cause of death Myocardial degeneration & insufficiency with congestive failure

Due to Arteriosclerotic heart disease hypertrophy

Due to Generalized arteriosclerosis with hypertension

Duration: 2 months; several years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 901 Edmondson Ave. Date signed Sept 5 45

VS 180

X

A 43082 EBB born

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632174

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dolores Eggborn -

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 36

8. AGE: Years	Months	Days	If less than one day
9	7	11	hr. min.

9. Birthplace Md -
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Jacob Eggborn -
13. Birthplace Pa -

MOTHER — 14. Maiden Name Hazel Frye -
15. Birthplace Pa. Da -

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 10, 1945 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Harpers Ferry W. Va.

18 (a) Funeral director Elliott Funeral Home
(b) Address 2008 Orleans St.

SEP 7 - 1945 (Date rec'd by Registrar) (c) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1, 1945 to Sept 6 1945 and that I last saw her alive on Sept 6 1945

Immediate cause of death	Cardiac failure	Duration
Due to	Toxemia	
Due to	Aspiration pneumonia	
Other Conditions	Staphylococcal Septicemia	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Harrison Clark Spurrier
Address Johns Hopkins Hop Date signed M. D. 9-6-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 c

Registered No. G32175

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE PENCIL, WITH CARBONING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garris on Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MABEL KNAUFF

3 (b) If veteran, name war –

3 (c) Social Security Account No. 212-03-6987

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1885

8. AGE: Years 59 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Operator

11. Industry or business C & P Telephone Co.

FATHER
12. Name Charles Abbott Knauff
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Agnes Nicol
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Agnes Knauff
(b) Address 1938 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 7 – 1945 Huntington Williams, M.D. Registrar
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1945 to Sept 3 1945 and that I last saw h[illegible] alive on Sept 3 1945

Immediate cause of death
(a) Coronary Thrombosis
Due to (b) Hypertension
Due to (c) Arteriosclerosis
Due to (d)

Duration 1 day
2 Mos
4 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry C. Houck, M.D.
Address 1607 W. North Ave. Date signed Sept 5 1945

G32176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G32176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 N. Caey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 N. Caey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Bean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colred | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Earl Bean.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1912

8. AGE: Years 32 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name James Lewis
13. Birthplace Va

MOTHER
14. Maiden Name Florence Hayes
15. Birthplace Ne

16 (a) Informant Earl Bean
(b) Address 1112 N. Casey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

SEP 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1945, to 9-4 1945 and that I last saw h[illegible] alive on 9-4 1945

	Duration
Immediate cause of death Cardiac arrest.	2 days
Due to myocarditis	1 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. N. Pitt M.D.
Address 1536 W. Lanvale St. Date signed 9-6-45

VS 3

X

G32177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G32177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4121 Fairview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Belair Rd & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 SEP 7 1945 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1945, to Sept 6 1945 and that I last saw him alive on Sept 6 1945.

Immediate cause of death Chronic fibroid Tuberculosis Pneumonia and Bronchogenic Spread — Duration

Due to Hypertensive Cardio-Vascular Disease

Due to Diabetes Mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia, Coronary artery disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold Katz M. D.
Address Sinai Hosp Balt. Md. Date signed 9-6-45

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G32178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. G32178

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... INK. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walkens + Caton Aves.
(c) Hospital or institution: St Agnes Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 Woodridge Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lawler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-45

8. AGE: Years	Months	Days	If less than one day
	1	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine M. Stein
15. Birthplace Md.

16 (a) Informant Wm Lawler
(b) Address 3814 Woodridge Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Calvert St

19 SEP 7 - 1945 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1945, at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1945 to 8-6 1945 and that I last saw him alive on 8-6 1945

Immediate cause of death Malnutrition - Dehydration

Due to Bilateral Cleft palate and Hare Lip.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cuthbert T. Hull Jr.
Address St. Agnes Hosp. Date signed 9/7/45

X

G32179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32179

Registered No. 87c

Entry Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1641 N. Bond St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1641 N. Bond St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Elizabeth Detlof

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~August~~ August M. F. Detlof

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17th 1880

8. AGE: Years 65 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Martin Reisinger

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Wilhelmina (Unknown)

MOTHER 15. Birthplace Germany

16 (a) Informant Ellsworth Bischoff

(b) Address 903 Andover Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Maryland Park

Location Parkville Md.

18 (a) Funeral director William Cox Inc.

(b) Address 6342 St. Paul St.

19 SEP 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 402 E. Lanvale

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1945 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to Sept. 5 1945 and that I last saw ~~deceased alive~~ on Sept. 3 1945

Immediate cause of death Parkinson's Disease — Duration 11 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. H. Draenger M.D. Date signed 9.6.45

VS 150

G32180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 112

Registered No. G32180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 Boone St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 2621 Boone St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1875

8. AGE: Years	Months	Days	If less than one day
70	6	22 21	hr. min.

9. Birthplace Richmond VA
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Edward Burrell
13. Birthplace VA.

MOTHER
14. Maiden Name Jane Burrell
15. Birthplace VA.

16 (a) Informant Allen Saunders
(b) Address 1201 N Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1945 (month) (day) (year)
(c) Cemetery or crematory Richmond Va
Location Henrico County

18 (a) Funeral director Joseph A Sirgly
(b) Address 4000 Roland Street

19 (a) Date received by Registrar SEP 7 1945 (b) Huntington Willis, Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945, at 6 05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 6, 1945

G32181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G32181

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 Pierce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Pierce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Vernon Hatchett

6 (c) If alive, give age years

7. Birth date of: February (mo.) 22 (day) 1909 (yr.)

8. AGE: Years 39 | Months 6 | Days 11 | If less than one day hr. min. 10

9. Birthplace: Balto Md (Town, county and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Wm Hill
13. Birthplace: Md

MOTHER
14. Maiden Name: Jane Worda
15. Birthplace: Prince George Co Md

16 (a) Informant: Dorothy Diggs
(b) Address: Mathews Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7 1945 (month) (day) (year)
(c) Cemetery or crematory: Western Star
Location: Baltimore County

18 (a) Funeral director: Joseph A Sipsky
(b) Address: 408 N Mount Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/45 19 at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to Sept 1 1945, and that I last saw him alive on 9/3/45 19

	Duration
Immediate cause of death: Acute Dilatation	unknown
Due to: Carcinoma uterus	unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Hatch T Gosson

Address: 402 Edmondson Ave Date signed: 9/5/45

G32182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G32182

Please write plainly in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Barrington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Barrington Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HENRY STAHM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie Stahm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1868

8. AGE: Years	Months	Days	If less than one day
77	6	0	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Stahm
13. Birthplace Germany

MOTHER
14. Maiden Name Hanna More
15. Birthplace Germany

16 (a) Informant Mrs. Jesse M. Derr
(b) Address 3703 Barrington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 7 - 1945 (Date rec'd by registrar) Harrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1945 at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Sept 1945 and that I last saw h. alive on 9/3 1945.

Immediate cause of death Uraemia — Duration
Due to Carcinoma of prostate
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 4710 Eastern Ave. Date signed 9/6/45

VS 150

G32183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G32183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution St Joseph Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald E. Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25 1942

8. AGE: Years	Months	Days	If less than one day
3	6	12	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Donald E. Simmons
13. Birthplace Md

MOTHER
14. Maiden Name Frances M. Sadler
15. Birthplace Md

16 (a) Informant Mrs. Donald E.
(b) Address 2227 N. Aisquith St

17 (a) Buried (b) Date thereof 9-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director L. J. Cook
(b) Address 305 Harford Rd

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1945 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2/45 19.. to 9/6 1945 and that I last saw him alive on 9/6 1945.

Immediate cause of death	Duration
Toxemia	
Due to Burns on body and face.	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/2/45 at 3 P M
(c) Where did injury occur? Bush River (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Shore (Specify type of place) While at work? No
(e) Means of injury Explosion Gasoline

23. Signature Melvin Simmons
Address St Joseph Hospt Date signed 9/8/45

Thomas J. Devereux, M.D. X

VS 180

1945
1946

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G32184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. ~~1234~~ 634 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-14-25

8. AGE: Years 20 | Months 9 7 | Days 20 | If less than one day hr. min.

9. Birthplace Charlestown, W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John R. Harris
13. Birthplace W. Va.

MOTHER 14. Maiden Name Elizabeth D. Wood
15. Birthplace Wash. D.C.

16 (a) Informant Mrs. Eliz. W. Harris
(b) Address 634 W Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto., Md.

18 (a) Funeral director Charley R. Law
(b) Address 802-04 Madison Ave.

19 (a) 9/7/45 (Date filed by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3, 1945 at 9 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-45 at 9 P. M.
(b) Where did injury occur Lafayette Ave. west of Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 9-4-45

VS 151

(over)

X

G32185 ✓ G32185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Please answer every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 N. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 N. Wolfe St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith L. Kent

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Kent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1886

8. AGE: Years 58 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Essex Co., Va.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name George Robinson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace Va.

16 (a) Informant Mrs. Evelyn G. Weinhold
(b) Address 1820 E. Lafayette Ave.,

17 (a) Burial (b) Date thereof 9-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Edward J. Fleming & Son
(b) Address 1938 E. Lafayette Ave.,

19 (c) SEP 7 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1945 at 10.25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Sept 5 1945, and that I last saw h[illegible] alive on Sept 3 1945

Immediate cause of death: Chronic myocarditis — Duration: 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Finn Moore M. D.
Address 3105 Belair Rd Date signed 9-7-45

VS 150

X

G32186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

G32186 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Belmont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. Edwards

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-6619

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace L. Edwards
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	4	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Store Keeper
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Charles J. Edwards
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia A. Douglas
15. Birthplace Va.

16 (a) Informant Mrs. Grace M. Edwards
(b) Address 3014 Belmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director C. Howard Strong
(b) Address 3207 W. North Ave
Huntington Williams, M.D.

19 (a) (Date received by Registrar) (b) Registrar

SEP 7 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1945, to 9-6-1945, and that I last saw him alive on 9-6-1945.

Immediate cause of death	Duration
Shock	
Due to Surgical Operation (?) Cyclopropane (?)	
Due to Peripheral circulatory collapse	
Other Conditions Carcinoma Rectum	

(Include pregnancy within 3 months of death)

Date of operation 9-5-45
Major findings of operation: Carcinoma Rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Ingram M.D.
Address University Hospital Date signed 9-6-45

X

G32187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

G32189

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country Germany

3 (a) FULL NAME John Blankenheim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1. 1867

8. AGE: Years	Months	Days	If less than one day
78	4	5	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Blankenheim
13. Birthplace Germany

MOTHER 14. Maiden Name
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Filed SEP 7 1945 (b) Registered by [illegible] Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945, to Sept 6 1945, and that I last saw him alive on Sept 5 1945

Immediate cause of death	Duration
Edema of Lungs	3 days
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Arteio Sclerosis	6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall, M. D.
Address 1631 E North Ave Date signed 9/6-45

VS 150

G32188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G32188

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 N. Green St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25-yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Green St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FILIA ZAPPA

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife STAMATIOS ZAPPA
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25-1880

8. AGE: Years	Months	Days	If less than one day
64	11	9	hr. min.

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John Spanos
13. Birthplace Turkey

MOTHER
14. Maiden Name Mary ——?
15. Birthplace Turkey

16 (a) Informant Mrs Dimitrios Barotis
(b) Address 416 N. Green St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-45 (month) (day) (year)
(c) Cemetery or crematory Greek Cemetery
Location Wyndsor Mill Rd.

18 (a) Funeral director Lambros Funeral Home Inc
(b) Address 420 E North Ave

19 SEP 7 - 1945 (Date rec'd by Registrar) (b) Huntington-Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1945 to Sept 4 1945. and that I last saw h[illegible] alive on Sept 4 1945

Immediate cause of death	Duration
(1) Acute Myocarditis	7 days
Due to Coronary Thrombosis	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles S Mentadt M. D.
Address 1730 Linden Ave Date signed 9/5/45

VS 160

X

G32189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

Registered No. G32189

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Fremont Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Plater

3 (b) If veteran, name war No

3 (c) Social Security Account No. 219-10-2640

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age 5 Years

7. Birth date of deceased (mo., day, yr.) 12/22/1887

8. AGE: Years 62 | Months 8 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Balto md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Harry Plater

FATHER 13. Birthplace Balto md

MOTHER 14. Maiden Name Hannah ?

MOTHER 15. Birthplace Balto md

16 (a) Informant Pauline Plater

(b) Address 111 N. Arch St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto. md.

18 (a) Funeral director Chas. H. Coffin

(b) Address 512 N. Carrollton Ave.

19 (a) Date rec'd by Registrar SEP 7 1945 (b) Signature of Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1945, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dislocation of 3rd cervical vertebra.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/3/45 at 8 A.M.

(b) Where did injury occur? 1235 Fremont Ave

(c) Did injury occur at home, on farm, industrial place, in public place? 1215 Mulberry St While at work? No

(d) Means of injury: Fell down stairs

23. Signature Howard J. Walker M.D. (Medical Examiner.)

Date signed 9-4-45

Transcript

G32190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Beaufort Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5221 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Maher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Jeremiah Maher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16 - 1868

8. AGE: Years	Months	Days	If less than one day
77	6	18	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Delaney
13. Birthplace Ireland.

MOTHER
14. Maiden Name Margaret Morrisey
15. Birthplace Ireland

16 (a) Informant Mrs. Alice D. Enoss
(b) Address 5319 Wesley Ave

17 (a) Burial (b) Date thereof 9-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore Md.

18 (a) Funeral director Loring Byers
(b) Address 5215 Park Heights Ave

19 (a) SEP 7 - 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Sept 6 1945 and that I last saw h[er] alive on Sept 5 1945

Immediate cause of death	Duration
Myocarditis	1 yr
Due to Arteriosclerosis	
Due to Senility	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles J. Treen
Address 776 Park Hgts Date signed Sept 7 45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G32191
1 - Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G32191 Registered No. [illegible]

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITING OR PRINTING WITH INDELIBLE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Woodland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Martin Melsage

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida Parker Melsage
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1897

8. AGE: Years	Months	Days	If less than one day
47	9	24	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business PO

FATHER
12. Name August Melsage
13. Birthplace Europe

MOTHER
14. Maiden Name Alvira ?
15. Birthplace Europe

16 (a) Informant Records - U.S. Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director Lorenz Myers Funeral Home
(b) Address 500 E Baltimore ave

SEP 7 - 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 190

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 6 1945, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1945, to Sept 6 1945, and that I last saw him alive on Sept 6 1945.

Immediate cause of death	Duration
Pulmonary embolism suspected; chronic glomerulonephritis.	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U.S. Marine Hospital Date signed 9/ /45

X

G32192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

G32192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 172 W. Cross Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ed Jones
13. Birthplace Georgia

MOTHER
14. Maiden Name Pearl Jackson
15. Birthplace Georgia

16 (a) Informant Dandy Mimms
(b) Address 1619 W Franklin

17 (a) Removal (b) Date thereof 9-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Savannah
Location Georgia

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St.

19 SEP 7 - 1945 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 45 19, at 11:50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of Aorta

Due to Syphilitic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraser M.D.
Medical Examiner.
Date signed September 6, 1945.

G32193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No. G32193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 Sterling St.
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 Sterling St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Malvina Murray

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Arthur Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1885

8. AGE: Years 60 | Months 1 | Days 28 | If less than one day - hr. - min.

9. Birthplace King & Queen Co Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name Tyler Braxton

13. Birthplace King & Queen Co Va

MOTHER

14. Maiden Name Julia Harris

15. Birthplace King & Queen Co Va

16 (a) Informant Carrie Quickley

(b) Address 731 Sterling St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9-8-45 (month) (day) (year)

(c) Cemetery or crematory Lancaster Va

Location Virginia

18 (a) Funeral director Payne Sanders

(b) Address 1412 E. Preston St.

19 (a) (b) Huntington Williams, Mortician

Sep 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1945 to 9/5 1945 and that I last saw her alive on 9/5 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Ruth Blighton M. D.

Address 501 Cherry Hill Rd (Date signed 9/6/45

X

Expect age is especially important. Physicians: please write the causes of death clearly and legibly. Every item should be carefully supplied. The information

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G32194 (Registered No.) G32194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Warren Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gladys

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 2, 1909

8. AGE: Years 36 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER 12. Name William Clark

13. Birthplace Pa.

MOTHER 14. Maiden Name Hattie Henderson

15. Birthplace Md.

16 (a) Informant Gladys Clark

(b) Address 1556 Chuck St.

17 (a) Removals (Burial, cremation, or removal) (b) Date thereof Sept 7/45 (month) (day) (year)

(c) Cemetery or crematory

Location Coatesville Pennsylvania

18 (a) Funeral director Mrs. Robert A. Elliott

(b) Address 1129 N. Caroline St.

SEP 7 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1945, at 12:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Sept 6 1945

G32195 ✓ G32195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Ashland Court
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Ashland Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora M. Schneider

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) June 7th 1871

8. AGE: Years 74 | Months 2 | Days 29 | If less than one day ###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Sebastian Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Stenger
15. Birthplace Germany

16 (a) Informant Miss. Elizabeth Schneider
(b) Address 1010 Ashland Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

SEP 7 1945 (Date Registered) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1945 to Sept 6 1945, and that I last saw h[illegible] alive on Sept 5 1945

Immediate cause of death Cancerous Tumor — Duration 4 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. F. A. Stevens

Address 2878 Harford Rd Date signed 9/6/45 M. D.

VS 160

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G32196 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Welcome Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Venable

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-12-1932

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1901

8. AGE: Years	Months	Days	If less than one day
44	3	25	hr. min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual Occupation Ship Fitter

11. Industry or business Ship

FATHER 12. Name Morris Venables
13. Birthplace Salisbury Md.

MOTHER 14. Maiden Name Susie Pikett
15. Birthplace Mt. Vernon

16 (a) Informant Randolph Venables.
(b) Address 1004 Gale St. Wash. D. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/7/45 (month) (day) (year)
(c) Cemetery or crematory Salisbury Md.
Location WALTER B. SPRIGGS.

18 (a) Funeral director 139 W. Hamburg
(b) Address 1515 Madison Ave

19 (a) (Date rec'd by Registrar) (b) Registrar

FEB 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1945, at 1:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 3rd 1945 12:20 A.M.
(b) Where did injury occur? 131 Welcome Alley
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? Yes
(d) Means of injury Stabbed

23. Signature Robert Lee Fortune M.D. Medical Examiner.
Date signed Sept 3rd 1945

X

G32197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G32197 Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Hillsdale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2211 Hillsdale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Wells

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race N | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo. E. Wells
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 6/6/1874

8. AGE: Years 71 | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Benjamin Dorsey
13. Birthplace Md.

MOTHER 14. Maiden Name Annie Bell Turner
15. Birthplace Geo. E. Wells Md.

16 (a) Informant
(b) Address 2211 Hillsdale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director J. B. Shipley & Son
(b) Address 300 Eastern Blvd

19 (a) (Date received by registrar) (b) Huntington-Williams Mfg

SEP 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 6 1945
and that I last saw h alive on Sept 5 1945

Immediate cause of death	Duration
Carcinoma of Liver	1 yr
Due to	
Due to Cirrhosis Liver	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Gibney M. D.
Address 6 W Biddle Baltimore Date signed 9/7/45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32198 Registered No. 107

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 Howard Park Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles Franklin Dinsmore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gunnie M. Dinsmore
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 6, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	0	hr. min.

9. Birthplace Harford County, Md.
(Town, county, and state)
10. Usual Occupation Die Setter (Machinist)
11. Industry or business

FATHER
12. Name William Dinsmore
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Elizabeth Tollinger
15. Birthplace Maryland

16 (a) Informant Mrs. Charles F. Dinsmore
(b) Address 3701 Howard Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lamotray
(b) Address 4510 Liberty Heights Ave.

19 Filed by [illegible] Huntington Williams, M.D.
SEP 8 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945; at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 19 45 to 9/6 1945
and that I last saw him alive on 9/6 19 45

Immediate cause of death Bronchopneumonia — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 9/6/45

X

G32199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32199 / 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 S. Catherine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 S. Catherine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie J. Boardman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frederick L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1870

8. AGE: Years 76 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name — Leamon

13. Birthplace England

14. Maiden Name —

15. Birthplace —

16 (a) Informant Frederick L. Boardman

(b) Address 14 S. Catherine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.8.45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn Md.

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 E. Monument

19 SEP 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1945 to 9/5 1945 and that I last saw h[illegible] alive on 9/5 1945

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.

Address 2030 W Ilkens Date signed 9/7/45

VS 150

The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

147 d

G32200 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparrows Point, Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Forest Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Howell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1874

8. AGE: Years	Months	Days	If less than one day
71		18	hr. min.

9. Birthplace Trenton N. J. (Town, county and state)

10. Usual Occupation Railroad (Retired)

11. Industry or business

FATHER
12. Name Isaac Howell
13. Birthplace N. J.

MOTHER
14. Maiden Name Emma Prevost
15. Birthplace N. J.

16 (a) Informant Mr Howell (nephew)
(b) Address 1329 Forest Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Pleasantville, N. J.

18 (a) Funeral director D. L. Covington
(b) Address 21 W. 25th St. Balto 18 Md
(c) [illegible] Huntington Williams, Mgr.

SEP 8 - 1945 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1945 to 9-7 1945, and that I last saw him alive on 9-7-1945.

Immediate cause of death	Duration
Surgical Shock	
Due to Pneumonectomy	
Due to	
Other Conditions Squamous cell epithelioma of lung (Include pregnancy within 3 months of death)	

Date of operation 9-7-45

Major findings of operation: Squamous cell cancer.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Hosp. Date signed 9-7-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32201

472559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1171

G32201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2840 Tyrone Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna E. Hall
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen M.
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 12-14-04

8. AGE: Years	Months	Days	If less than one day
41	2	23	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Insurance Collector
11. Industry or business

FATHER
12. Name J. E. Hall.
13. Birthplace Va.

MOTHER
14. Maiden Name Anna R. Edwards
15. Birthplace Va

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery Elmwood
Location Norfolk Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st

19 SEP 8 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 - 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 24 1945 to Sept 7 1945 and that I last saw him alive on Sept 7 1945

Immediate cause of death Shock — Duration

Due to Acute Hemorrhagic Pancreatitis

Due to Post operative Toxic Reaction

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation Aug. 31 1945

Major findings of operation: Duodenal Ulcer

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. A. Cooley
Address The J. H. Hospital Date signed 9-7-45 M. D.

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6632202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 6632202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Balto., City (Bel Air)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mackey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/27/45

8. AGE: Years | Months | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Howard B MacKay

13. Birthplace

MOTHER 14. Maiden Name Nancy Richardson

15. Birthplace Md

16 (a) Informant Hospital Records

(b) Address Granny Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/45 (month) (day) (year)

(c) Cemetery or crematory St Mary's

Location Emmorton, Md

18 (a) Funeral director Deems & Foster

(b) Address Bel Air Md

19 (a) Filed SEP 8 1945 (b) Huntington Williams, M.D.

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1945, at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1945 to 9/7 1945, and that I last saw h/m alive on 9/7 1945.

Immediate cause of death Prematurity (2 lbs - 14 ozs).

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mackey M. D.

Address University Hosp. Baltimore Md. Date signed 9/7/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TYPE OR PRINT PLAINLY, WITH UNFADING INK.

G32203 Roosevelt H. Veney G32203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. V119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Stricker St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Roosevelt Veney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Negro. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-45

8. AGE: Years 0 | Months 3 | Days 4 5 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Infant.

11. Industry or business

FATHER
12. Name Ernest Morgan.
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Peavey.
15. Birthplace Baltimore, Maryland.

16 (a) Informant Elizabeth Veney.
(b) Address 218 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8' 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Wm. Winans

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 1915 N. Dolphin St.

SEP 8-1945 (Date rec'd by registrar) (a) Huntington Williams Mort.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1945, to 9-7 1945, and that I last saw him alive on 9-6 1945.

Immediate cause of death Cachexia, (starvation)
Due to Diarrhea
Due to Dehydration
Other Conditions Malnutrition; Anemia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Redding M. D.
Address 426 N. Gilmor Date signed 9-8-45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G32204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32204
Registered No.

CMK-91526

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 7- 26
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4511 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charity Opie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ? ?

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace Baltimore-Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan Cook
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Liberty Heights, Balto Co

18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Lynnhurst Hall Ave
Huntington Williams Mgr
SEP 8 1945 (Date received by Registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 6 1945, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 12 1945, to Sept. 6 1945, and that I last saw her alive on Sept. 6 1945.

Immediate cause of death Bronchopneumonia — Duration 2 da.

Due to Arteriosclerotic heart disease with decompensation.

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave Date signed 9-7-45
Balto., Md.

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G32205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55L

Registered No. G32205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 N. Colvin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 N. Colvin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Isaac (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/26/1892

8. AGE: Years 53 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Maid

11. Industry or business

FATHER
12. Name Charles Bailey
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary ?
15. Birthplace Delaware

16 (a) Informant Evelyn Lee
(b) Address 1226 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md

18 (a) Funeral director Joseph D. Lockard
(b) Address 1364 N. Central Ave

19 SEP 8 - 1945 (Date rec'd by registrar) Registration District No. Williamson

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1945 at 12 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945 to Sept 5 1945, and that I last saw her alive on Sept 5 1945.

Immediate cause of death Acute cardiac Dilatation

Due to Abdominal malignancy

Due to

Other Conditions Cirrhosis Ascites Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury 2

23. Signature Marcus A. Finn M. D.

Address 1E Biddle St. Date signed

VS 180

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITING OR PRINTING IN INK.

G32206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G32206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Wilkens Pkwy 9
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice McNulty

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Leo P. McNulty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-16-03

8. AGE: Years 42 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Baker
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Maryland

16 (a) Informant record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)
(c) Cemetery or crematory Mem. Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Conkling & Son
(b) Address 924 E. Eager St.

19 (a) SEP 8 1945 (Date received by Registrar) (b) Registrar for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1945, at 12 4D P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-45 1945 to 9-7 1945 and that I last saw h[illegible] alive on 9-7 1945

Immediate cause of death: Carcinoma (Uterus) (Reported)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gabriel A. Vance
Address Johns Hopkins Hospital Date signed 9/7/45

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT PLAINLY, WITH UNFADING INK.

G32207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No. G32207

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address: Edmondson Ave. North Rear
(c) Hospital or institution: Hood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 72 S Morley st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret O Hasenkamp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1873

8. AGE: Years 72 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James McEneery
13. Birthplace Not Known

MOTHER
14. Maiden Name Margaret O'Toole
15. Birthplace Not Known

16 (a) Informant John Hasenkamp
(b) Address 72 S Morley st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balt Md

18 (a) Funeral director Geo. A. Tinley
(b) Address Guilford Ave & Lafayette

SEP 8 1945 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1945, at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 8 1945 and that I last saw h alive on 8/8 1945

Immediate cause of death Carcinoma of Stomach.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 1st 1945

Major findings of operation: Carcinoma of stomach.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Dunler M.D.
Address Medical arts Bldg Date signed 9/10/45

VS 186

IMPORTANT—WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161 C

Registered No. G32208

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Heatherwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schaltheis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife Not married

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Sept 8 1945

8. AGE: Years	Months	Days	If less than one day
			hr. 2 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Hayes
15. Birthplace New Jersey

16 (a) Informant Owner
(b) Address 203 Heatherwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 45 (month) (day) (year)
(c) Cemetery or crematory Bethesda
Location Balto Md

18 (a) Funeral director Hen A Farley
(b) Address Fayette & Fremont

19 SEP 8 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945 at 3:13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 3:10 PM 45 to 9/7 3:15 PM 45 and that I last saw h/m alive on 9/7 1945.

Immediate cause of death Cyst of Mediastinis Fontalis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Lewis Wilkinson
Address St Agnes Hosp Date signed 9/9/45

X

G32209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hospital 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13day
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Virginia Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Long

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/45

8. AGE: Years | Months | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Long
13. Birthplace

MOTHER 14. Maiden Name Delores Vatenmay
15. Birthplace Akron Ohio

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto Md

18 (a) Funeral director George A. Farley
(b) Address Fayette & Fulton

19 Date received by Local Registrar SEP 8 1945 (b) Huntington Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1945 at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945 to 9/3 1945, and that I last saw her alive on 9/3 1945

Immediate cause of death Respiratory distress and anoxemia — Duration

Due to Prematurity, 36 wks pregnancy

Due to Necessity of performing Cesarean Section on Mother

Other Conditions Poor nutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Reed, M.D.
Address Mercy Hospital Date signed 9/3/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered G32210

The ... supplied ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2846 Parkwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2846 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT E. L. WOOLF

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1881

8. AGE: Years 64 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business self

FATHER
12. Name Hamilton E. Woolf
13. Birthplace Charleston S. Carolina

MOTHER
14. Maiden Name Hanna Frank
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. Lewis F. Woolf
(b) Address 2100 Bryant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/45 (month) (day) (year)
(c) Cemetery or [illegible] Baltimore Hebrew
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS.
(b) Address Baltimore, Maryland

SEP 8 1945 (Date rec'd) Thurlington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1945 at [illegible] M

21. I certify that death occurred on the date above stated at [illegible] and deceased from MCH 14 to Apl 18 1945 and that I last saw h[illegible] alive on Apl 18 1945

Immediate cause of death Coronary Thrombosis 6 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Davis M.D.
Address 403 Med Arts Date signed 9-7-45

For S. J. R. Davis, - by Howard J. Mueller, M. D.

G32211

JL - 94482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

Registered No. G32211

The information should be carefully supplied. Every item of information should be carefully supplied. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 4 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 S. Eaton St. (If rural give location) 9
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Rychwalski

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	705-03-6039	Male	White	Married

6 (b) Name of husband or wife Rosalie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1885

8. AGE: Years	Months	Days	If less than one day
60	0	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation BOILER MAKER
11. Industry or business B & O RR. SHOPS

FATHER
12. Name Stanley Rychwalski
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Thursday
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 11/45 (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location GERMAN HILL ROAD

18 (a) Funeral director Leillyn Zeiler Inc.
(b) Address 403 S. WOLFE ST.

(a) SEP 8 1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945 at 3.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945 to Sept. 6 1945 and that I last saw h im alive on Sept. 6 1945

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathon Howland M. D.
Address B C H Date signed 9/6/45

VS 150

G32212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G32212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2648 Huntington Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Huntington Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HENRY WISNER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	no	M	W	Widowed

6 (b) Name of husband or wife Ida Estelle Wisner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1849

8. AGE: Years	Months	Days	If less than one day
96	1	7	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Builder
11. Industry or business

FATHER
12. Name William Wisner
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Jeanette Moore - Daughter
(b) Address 2648 Huntington Ave.

17 (a) Burial (b) Date thereof 9- 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 8 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to Sept. 7, 1945
and that I last saw h[illegible] alive on 9/7 1945.

Immediate cause of death	Duration
Broncho-pneumonia	4 days
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature A. Weiss M. D.
Address 1927 E. North Ave. Date signed 9-7-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 9-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Lakeside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aloysius Lawrence ALOYSIUS HENRY LAWRENCE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, (Married), widowed, or divorced. Married

6 (b) Name of husband or wife Johanna M. Lawrence

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) July 31, 1869

8. AGE: Years 76 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Mill Worker

11. Industry or business

FATHER
12. Name James Lawrence
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Trunk
15. Birthplace Germany

16 (a) Informant Mr. Thomas Lawrence
(b) Address 1306 Lakeside Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1945 at 12 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1945, to Sept 6 1945, and that I last saw h... alive on Sept 6 1945.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerotic heart disease

Due to

Other Conditions Operable cancer (abdominal)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Vera Clark M. D.
Address University Hosp. Date signed 9-6-45

VS 159

THIS CERTIFICATE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G32214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Eagle St
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Delverne Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GUSTAV P. PENSEL

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-01-0759

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife CLARA M. PENSEL
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1872

8. AGE: Years	Months	Days	If less than one day
72	0	0	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name WILLIAM S. PENSEL
13. Birthplace German

MOTHER
14. Maiden Name MARGARET PAUL
15. Birthplace German

16 (a) Informant Charles F. Whorton
(b) Address 3703 Delverne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 8-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1944 at 9 4.5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Sept 7 1944 and that I last saw h[illegible] alive on Sept 7 1944.

Immediate cause of death	Duration
Carcinoma of Sigmoid with Generalized meta-	2
Due to stasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/4/44
Major findings of operation: See above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Madison Bloom III M. D.
Address Sinai Hosp. Date signed 9/7/1944

VS 150

Hosp X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Sydney

G32215 — BALTIMORE CITY HEALTH DEPARTMENT ✓ G32215

CERTIFICATE OF DEATH 108

Registered No. G32215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City~~ or town 2120 Chelsea Terrace
(If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ Baltimore
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Gorden James Hasenei

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5591

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dorothy T. Hasenei
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1917

8. AGE: Years	Months	Days	If less than one day
28	----	29	..... hr. ..... min.

9. Birthplace McKeesrock Pa.
(Town, county, and state)
10. Usual Occupation Groceryman
11. Industry or business

FATHER
12. Name James J. Hasenei
13. Birthplace Unknown

MOTHER
14. Maiden Name Minnie Schimpf
15. Birthplace Pennsylvania

16 (a) Informant Dorothy Hasenei
(b) Address 2120 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Md.
Location Woodlawn Md.

18 (a) Funeral director Harry N. Armacost
(b) Address 4204 Ridgewood Ave.

19 (a) 9/7/1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1945 to 9/6 1945 and that I last saw him alive on 9/6 1945

Immediate cause of death	Duration
Respiratory & Peripheral Circ. Collapse	
Due to Lobar Pneumonia	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 9/6/45

VS 8

X

Sydney 11

Cor. of age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

G32216 ✓G32216

472559.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Grebe Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bennett Tillman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) 4-5-16

8. AGE: Years	Months	Days	If less than one day
29.	4	29	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Stock Handler

11. Industry or business Weaton & Lester.

FATHER
12. Name Eli Tillman
13. Birthplace N. C

MOTHER
14. Maiden Name Beatrice Simmons
15. Birthplace N. C.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Sept. 9, 45 (month) (day) (year)

(c) Cemetery or crematory
Location Wadesboro N. C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 9-1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1945 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1945 to Sept. 7 1945. and that I last saw h alive on Sept. 7 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Advanced pulmonary tuberculosis	
Due to Tuberculous laryngitis	
Chronic glomerulonephritis	
Other Conditions Nephrotic syndrome	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Dilon
Address Johns Hopkins Hospital Date signed 9/7/45

Type or write plainly, with UNFADING INK. Every item of information should be carefully supplied. The most age is especially important. Physicians: please write the causes of death clearly and legibly.

G32617 ✓ x G32217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Bryan (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Horcha

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W.# 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/1908

8. AGE: Years	Months	Days	If less than one day
27	5	15	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation SOLDIER

11. Industry or business U.S. ARMY

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant U. S. Army
(b) Address Camp Holabird

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Bryan
Location Michigan

18 (a) Funeral director Selby & Sailor
(b) Address 493 S. HOLE ST.

19 (a) 9-11-1945 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6- 1945, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Death death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ Autopsy, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6 A.M. 9-6-45 12-3 M.
(b) Where did injury occur? B&O Railroad - Barclay Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury? Pedestrian? 3rd rail B&O R.R. tunnel

23. Signature Howard J. Mellenis M.D. Medical Examiner.
Date signed 9-6-45

VS 151

HEP G32218

BALTIMORE CITY HEALTH DEPARTMENT ✓ G32218

CERTIFICATE OF DEATH 13 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 - 0 - 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E. Preston Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Powers

3 (b) If veteran, name war NV | 3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1876

8. AGE: Years 69 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Upholsterer

11. Industry or business Upholstering

FATHER
12. Name John Powers (d)
13. Birthplace Md

MOTHER
14. Maiden Name Sophia Amish (d)
15. Birthplace Md

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1945 at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1945 to Sept. 7, 1945, and that I last saw him alive on Sept. 7, 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration unknown

Due to None

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Baltimore Md. Date signed 9-5-45

VS 150

X

G32219

BALTIMORE CITY HEALTH DEPARTMENT ✓ G32219 Registered No.

CERTIFICATE OF DEATH 51B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 19-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Lemmon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Mandell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: about 61 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory Mikro-Kodash
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) Clayton Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1945, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1945, to 9/7 1945, and that I last saw h[illegible] alive on 9/7 1945.

Immediate cause of death Cardiac Failure
a Pulmonary Edema — Duration 24 hours

Due to Questionable Rheumatic Heart Disease — 40 yrs.

Due to

Other Conditions Carcinoma of prostate with distal metastases — 1 yr.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca of prostate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Chernin M. D.
Address Date signed

95B

(2) correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32220 ✓ G32220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 Burgundy St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Burgundy St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph G. Knell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed
6 (b) Name of ~~husband or~~ wife: Irene Knell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26th 1872

8. AGE: Years 73 | Months 0 | Days 12 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Knell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Hooker
15. Birthplace Balto Md.

16 (a) Informant Marie Knell
(b) Address 908 Burgundy St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1945 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Aug 1945
and that I last saw h~~im~~ alive on Aug 6 1945.

Immediate cause of death	Duration
Cirrhosis of Liver	1 yr
Due to	
Due to	
Other Conditions Arteriosclerotic Cardio-Renal Disease (Include pregnancy within 3 months of death)	3 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. B. Fabiano
Address 5217 Harford Rd Date signed 9/10/45 M. D.

X

Please correct age if especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G32221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32221 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2786 W. North ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2786 W. North ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Bussy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	W

6 (b) Name of husband or wife Late Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1872

8. AGE: Years	Months	Days	If less than one day
73	1		hr. min.

9. Birthplace N.Y. N.Y.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Abraham Levy
13. Birthplace UK

MOTHER
14. Maiden Name UK
15. Birthplace UK

16 (a) Informant Mrs Jack Ottenheimer
(b) Address 2786 W. North ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E Baltimore st

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

Sept 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Sept. 8, 1945 and that I last saw her alive on Sept. 7, 1945

Immediate cause of death	Duration
Chronic Myocarditis	2 Yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Williams M.D.

Address 2786 W North Date signed 9/5/45

G32222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G32222 Registered No.

Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Mc Kewin Av
(c) Hospital or institution: 0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Mc Kewin Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Matilda Gawthrop

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Alfred C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31- 1877

8. AGE: Years 68 Months Days 7 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Frank Briano
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Eliza Elliott
15. Birthplace Balto Co - Md

16 (a) Informant Geo Mary E. Heil
(b) Address 723 Mc Kewin Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Pulaski Highway

18 (a) Funeral director John A Wilson
(b) Address 3 [illegible] Baltimore Md.

19 (a) 9-1945 (Date filed by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1945 to Sept 7 1945 and that I last saw h[illegible] alive on Sept 7 1945.

Immediate cause of death Carcinoma of Uterus — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury None

23. Signature L. L. Sandy MD

Address 5106 Harford Rd Date signed 9/8/45

VS 150

G32223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G32223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Tyson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Temple

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1942

8. AGE: Years 3 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Celester Hall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Edith Temple
15. Birthplace Baltimore, Md

16 (a) Informant Edith Temple (Mother)
(b) Address 903 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

SEP 9 - 1945 (Date filed by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1945 at 3 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s.d. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-6-45 at 2 40 P. 11/3 M.
(b) Where did injury occur? Read & Tyson Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Ped While at work? No
(d) Means of injury Struck by automobile

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 9-7-45

VS 151

G32224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Clarence Toney

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/4/1893

8. AGE: Years	Months	Days	If less than one day
52	6	1	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name George W. Toney
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary J. Woodland
15. Birthplace Balto. Md.

16 (a) Informant Mrs Mary Burton (Friend)
(b) Address 223 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Charles H. Wolfe
(b) Address 512 N. Carrollton Ave.

19 (a) (b) Victor Williams M.D. Registrar

10/8 Certificate rec'd by Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH September 5, 1945, at 3 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res. death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial failure,
Cardiac hypertrophy + dilatation

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Faulkner M.D.
Medical Examiner.
Date signed Sept 5 1945

USVS 151

G32225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

G32225 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1133 Park Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Ford Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C	Widowed

6 (b) Name of husband or wife James M. (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/1895

8. AGE: Years	Months	Days	If less than one day
50	1	19	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Moore
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Fauntleroy
15. Birthplace Va

16 (a) Informant Evelyn Ockimey
(b) Address 1133 Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location

18 (a) Funeral director Joseph B. Locke
(b) Address 1304 N. Central Ave

(a) (Signature of Registrar) (b) Registrar

SEP 6 1945

VS 130

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Sept 5 1945 and that I last saw h[er] alive on Sept 5 1945

Immediate cause of death Nephritis — Duration

Due to Hypertensive Cardiac

Due to

Other Conditions Disease.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X M. D.
Address 511 N. Jo[illegible] St Date signed 9/9/45

G32226 ✓ G32226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3002 Presbury St.

(c) Hospital or institution: Home 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) ------

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore, City

(c) City or town Baltimore, City (If outside city or town limits, write RURAL and give town) 16

(d) Street No. 3002 Presbury St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME: Alice Lorretta Finerty

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212 - 03 - 0118

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ----------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) June 22 - 1881

8. AGE: Years 64 (A bt. 63) | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore City, Maryland (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Shirt Industry

FATHER

12. Name Micheal Finerty

13. Birthplace Ireland

MOTHER

14. Maiden Name Ellen Mahoney

15. Birthplace Ireland

16 (a) Informant Miss Nellie J. Mitchell (Niece)

(b) Address 3002 Presbury St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 10 - 45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore City

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St. Balto. City

1945 Huntington Pallbearers, Md.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1945, at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945, to Sept 7 1945, and that I last saw her alive on 9/6 1945.

Immediate cause of death: Pernicious Anemia — Duration: ____

Due to: ____ — Duration: ____

Due to: ____ — Duration: ____

Other Conditions: ____ — Duration: ____

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ____ at ____ M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Alpha H Crowther

Address 4209 Hurd Ave Date signed 9/8/45 (M. D.)

VS 150

X

G32227 G32227 G32227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G32227

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2441 Lakeview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2441 Lakeview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1878

8. AGE: Years 67 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tire Business

FATHER
12. Name Louis Siegel
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Leavitt
15. Birthplace Russia

16 (a) Informant Annie Siegel
(b) Address 2441 Lakeview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10 45 (month) (day) (year)
(c) Cemetery or Beth Israel Southern Ave.
Location Smt. Ave

18 (a) Funeral director Sol. Levinson Bros.
(b) Address 1124-26 W. North Ave.

SEP 10 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 45, 335 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9, 1945, to Sept 9 1945, and that I last saw him alive on Sept 9, 1945.

Immediate cause of death Pulmonary Edema — Duration 4 hours

Due to Cardiac Decompensation — 3 years

Due to Coronary Insufficiency

Other Conditions Cardiac Hypertrophy, Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore Cooper M.D. M. D.

Address 2201 Eutaw Place Baltimore-17 Md. Date signed 9/9/45

VS 150

G32228

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G32228 Registered No. [illegible]

30C

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive
(c) Hospital or institution:
U. S. Marine Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 Mason Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Regan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 19, 1900

8. AGE: Years	Months	Days	If less than one day
45	4	18	hr. min.

9. Birthplace New Orleans, Louisiana
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Seafaring

FATHER
12. Name Cornelius Regan
13. Birthplace New Orleans La

MOTHER
14. Maiden Name Bridget Horan
15. Birthplace New Orleans La.

16 (a) Informant Records - U.S. Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Transit (b) Date thereof 9/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Patricks Cem
Location New Orleans La.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

19 (a) Date received (b) [illegible]

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH September 7 1945, at 6:10 M

21. I certify that death occurred on the date above-stated; that I attended deceased from Aug. 31 1945 to Sept 7 1945, and that I last saw him alive on Sept 7 1945.

	Duration
Immediate cause of death Encephalitis hemorrhagic	7 days
Due to (or as)	
Due to	
Other Conditions { Syphilis, cerebrospinal; Pneumonia, bronchial, terminal, left lower lobe	Sev. days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John L. Wilson M. D.
Address U.S. Marine Hospital Date signed 9/8/45

Sept 10 1945 Huntington Williamsport Md

VS 150

G32229 ✓ 93-d G32229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

The information requested on this certificate is necessary for the registration of the death and the issuance of a burial permit. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5609 Fair Oaks Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5609 Fair Oaks (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothea K. Reiss

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Reiss

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) 2/11/1866

8. AGE: Years 79 | Months 6 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name John Wittman
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Mrs. G. M. Reiss
(b) Address 5609 Fair Oaks Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Uhl's Funeral Home
(b) Address 2008 Orleans St

SEP 10 1945 (Date rec'd) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1945, at 3 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 9/7 1945, and that I last saw her alive on 9/7 1945.

Immediate cause of death Hypertension Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Haywood Bolley M. D.
Address 5703 Harford Ave Date signed 9/7/45

VS 150

G32230 ✓ G32230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 C

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 FOSTER AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM LADZINSKI (BABY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 3rd 1945

8. AGE: Years	Months	Days	If less than one day
	1	365	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JOSEPH LADZINSKI
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name MINNIE KRESSE
15. Birthplace BALTIMORE, MD

16 (a) Informant Mrs Kresse
(b) Address 3213 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Wilent Funeral Home
(b) Address 2608 Orleans St

(a) (Date received by registrar) (b) Registrar

SEP 10 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8 1945, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 25 1945 to SEPT. 8 1945, and that I last saw him alive on SEPT 8 1945.

Immediate cause of death	Duration
Dehydration, & Malnutrition	
Due to Infantile Diarrhea	15 days.
Due to	
Other Conditions Cyclical hematoma	36 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Wheeler M.D.
Address S. Balto. Gen. Hosp. Date signed Sept 8 '45

1190

G32231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G32231

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Baker
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F Van Horne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Susie Van Horne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1876

8. AGE: Years	Months	Days	If less than one day
69		21	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business Penn RR

FATHER
12. Name Benjamin Van Horne
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Schoelkopf
15. Birthplace Md

16 (a) Informant Mrs Susie Van Horne
(b) Address 2400 Eutaw Place

17 (a) Burial (b) Date thereof Sept 10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1945, at 6.05 PM

21. I certify that I took charge of the remains described above, held an J + I thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterio - sclerotic C V - renal disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Sinton M.D.
Medical Examiner.
Date signed 9/17/45

VS 15 SEP 18 1945 Clinton Williams M.D.

G32232

BALTIMORE CITY HEALTH DEPARTMENT 93d Registered No. G32232

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Delaware Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Horst

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-79

8. AGE: Years	Months	Days	If less than one day
65	10	9	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Conrad Horst
13. Birthplace Md

MOTHER
14. Maiden Name Swearinger
15. Birthplace Md.

16 (a) Informant Records Dept.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Johns
Location Baltimore Md

18 (a) Funeral director Wilson Lord Dee
(b) Address 1317 E Pratt St

SEP 10 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945 at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 9 1945, and that I last saw he alive on Sept. 9 1945.

Immediate cause of death Cardiac failure — Duration: 7

Due to Arterio sclerotic heart disease

Due to

Other Conditions Empyema, left Staphon Catarrhus, left (Include pregnancy within 3 months of death)

Date of operation 9-7-45

Major findings of operation: Lung abscess evac. lower left pulmonic cham

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Brendler. M. D.
Address 4 HH Date signed 9-7-45

VS 150

CAUTION: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 843 S. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 843 S. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry J. Fisher (Fischer)

3 (b) If veteran, name war World War # 1

3 (c) Social Security Account No. 211-01-1323

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Maude Dorsey

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 27, 1893

8. AGE: Years 52 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Chas. Fies Co.

FATHER 12. Name John B. Fisher

13. Birthplace Germany

MOTHER 14. Maiden Name Emma Meyer

15. Birthplace Germany

16 (a) Informant Mrs Maude Fisher

(b) Address 843 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Fredericks Ave

18 (a) Funeral director John F Henry Inc

Address 1348 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1945, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1945 to 9/8 1945 and that I last saw h alive on 9/8 1945.

Immediate cause of death: Acute Cardiac Failure — Duration 1 da

Due to: Coronary Disease — Duration 5 da

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dwight J. Lawrason M.D.

Address 1 E. Chesapeake St. Date signed 9/8/45

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G32234

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hackland & Payson
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Constantine Amatis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mildred Amatis
(b) Address 1626 W. Cross St

17 (a) Burial (b) Date thereof 9/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant
Location Gamber, Md

18 (a) Funeral director Joseph Kasinskas Jr.
(b) Address 602 Washington Blvd.

19 (a) (b)

SEP 10 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945 at 10 55 P M

21. I certify that death occurred on the date above stated: that I attended deceased from Sept 7 1945 to Sept 7 1945, and that I last saw him alive on Sept 7 1945

Immediate cause of death Pulmonary Edema — Duration

Due to Congestive Cardiac failure

Due to Rheumatic C.V.D. mitral insufficiency & stenosis

Other Conditions Contributing

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Baeslack M. D.
Address West Baltimore General Hospital 9/7/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Pokorny
32235 E. Madison

BALTIMORE CITY HEALTH DEPARTMENT ✓ G32235

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeanette Personette

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Warren Personette
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 19-1886

8. AGE: Years	Months	Days	If less than one day
59	—	18	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Williams Carmine
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret White
15. Birthplace Baltimore Md.

16 (a) Informant Warren G. Personette
(b) Address 2306 East Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore - Md.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver Street

19 (a) SEP 10 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6, 1945, at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 6 1945 and that I last saw her alive on Sept 6 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days

Due to: Hypertensive Cardio Vascular Renal Disease — 2.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny
Address 2200 E Madison St Date signed 9/7/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32236 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3428 Roland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3428 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice L. Wagner.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Wm. H. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1864

8. AGE: Years 81 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER
12. Name Alfred George
13. Birthplace England.

MOTHER
14. Maiden Name Martha Frances
15. Birthplace England.

16 (a) Informant Mrs. Clarence Frock.
(b) Address 817 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)
(c) Cemetery or crematory: London Park.
Location Industrial Road

18 (a) Funeral director: Clemens & Donovan
(b) Address 3615-17 Eastern Ave.

19 (Date received by registrar) SEP 10 1945 Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945, to Sept 7 19 45 and that I last saw h[er] alive on Sept 7 19 45

Immediate cause of death	Duration
arteriosclerosis	
Heart disease	
Due to Heart failure	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Wallgreen M.D.
Address 8 W 36th Date signed 9/8/45

VS 150

G32237

Lowe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G32237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Balt Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Ellamont St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernestine Lowe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Ignatz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd

18 (a) Funeral director Jerk Levy Sons
(b) Address 1439 E. Balto St.

19 (a) SEP 10 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945, to Sept 6 1945, and that I last saw h[illegible] alive on Sept 5 1945.

Immediate cause of death	Duration
Cerebral Embolism	made
Due to Chronic Cardio Vascular disease	15 yrs
Due to with Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H Zierler M. D.
Address 2318 Eutaw Pl Date signed 9/6/45

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 93d G32238 Registered No.

G32238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Pushkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Lydia nee Block

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 56 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Israel —
13. Birthplace Russia

MOTHER
14. Maiden Name Chassie —
15. Birthplace Russia

16 (a) Informant Lydia Pushkin
(b) Address 2338 Eutaw Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Wyerman Circle
Location Hebrew Mt Carmel

18 (a) Funeral director Jacob Reuss Inc
(b) Address 1439 E. Balto St

SEP 10 1945 (Date rec'd by Registrar) Thurlington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1945 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1945 to 9-8 1945 and that I last saw h alive on 9-8 1945

Immediate cause of death Myocardial infarction — Duration

Due to Coronary Thrombosis and insufficiency

Due to Arteriosclerotic Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L Rosenthal M. D.
Address Sinai Hospital Date signed 9-8-45

VS 190

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE PENCIL, WITH UNFADING INK.

G32239 Neiswender ✓ G32239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The ... PRINTING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South East. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life 57 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Georgesfield Ave (If rural give location)
(e) Citizen of foreign country? ... (Yes or No) If yes, name country ...

3 (a) FULL NAME Anna L. Neiswender

3 (b) If veteran, name war ...
3 (c) Social Security Account No. ...

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Ammon F. Neiswender
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 23. 1897

8. AGE: Years 52 | Months 1 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ...

FATHER 12. Name John Nagel
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Minnie Hinkle
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Nathan D. Friebd
(b) Address Lake Shore Rodgers P.O. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

SEP 10 1945 (b) Huntington Williams Md. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-45 19 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 9-7 1945, and that I last saw her alive on 9-7 1945

Immediate cause of death	Duration
Acute Hemorrhagic Pancreatitis	
Due to —	
Due to ...	
Other Conditions Shock	

(Include pregnancy within 3 months of death)

Date of operation 9-6-45

Major findings of operation Acute Hemorrhagic Pancreatitis

Autopsy? None

PHYSICIAN
Underline the cause to which death is to be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature George Barton M.D.
Address 1211 Light St Date signed 9-7-45

VS 150

G32240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 924 G32240

800 N. Pat. Pk.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3014 MAYFIELD AVE.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County BALTO

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 3014 MAYFIELD AVE. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: GEORGE C. TAPMAN

3 (b) If veteran, name war: W.W.# 1

3 (c) Social Security Account No. 215 10 3971

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MYRTLE TAPMAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 30 1894

8. AGE: Years 51 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation BOILER MAKER

11. Industry or business

FATHER

12. Name GEORGE TAPMAN

13. Birthplace BALTO. MD.

MOTHER

14. Maiden Name MINNIE THOMPSON

15. Birthplace BALTO. MD.

16 (a) Informant MYRTLE TAPMAN (WIFE)

(b) Address 3014 MAYFIELD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 12/45 (month) (day) (year)

(c) Cemetery or crematory US. NATIONAL

Location FREDERICK AVE.

18 (a) Funeral director Lilly - Feiler Co. Inc.

(b) Address 403 S. WOLFE ST.

19 (a) (Date received by Registrar) (b) Registrar

SEP 10 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 8 1945 at 2/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Sept 8 1945 and that I last saw him alive on Sept 8 1945

	Duration
Immediate cause of death: Mitral Stenosis	6 mo
Due to (or as a consequence of): Coronary Occlusion	
Due to (or as a consequence of): Primary Clerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature X RUZICKA

Address 800 W. Pratt St. Date signed Sept 10 1945 M.D.

71G32241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G32241 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 660 Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Fleming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1903

8. AGE: Years 41 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Fleming
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Holmes
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 '45 (month) (day) (year)
(c) Cemetery or crematory Zion Cemetery
Location B. A. Co., Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 10 1945 (b) Registrar Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1945, 2:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1945, to Sept. 7 1945, and that I last saw him alive on Sept. 7 1945.

Immediate cause of death: Myocardial failure — Duration

Due to: cause unknown

Due to:

Other Conditions: Hepatic failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Thomas Harland M. D.
Address D E H. Date signed 9/3/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32242 ✓ G32242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 Ogden
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 505 Ogden (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna London Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John London
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Josephine Rudd
(b) Address 518 Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 45 (day) (year)
(c) Cemetery or crematory Mt. [illegible]
Location Cremation Md.

18 (a) Funeral director Wm. Austin R. Williams
(b) Address 327 N. Schroeder Ave.

19 (a) Received SEP 10 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1945 to Sept. 6 1945.
and that I last saw h[illegible] alive on Sept. 6 1945.

Immediate cause of death Coronary Thrombosis — Duration 6 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9/6/45

G32243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G32243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asa Bert Rose

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jeannette Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1910

8. AGE: Years 35 | Months 5 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benton F. Rose
13. Birthplace W. Va

MOTHER
14. Maiden Name Maude McMillion
15. Birthplace W. Va

16 (a) Informant Mary Thompson
(b) Mgstwn, W. Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 10/45 (month) (day) (year)

(c) Cemetery or crematory
Location Morgantown W. Va

18 (a) Funeral director Phillip Henry Sons
(b) Address 2024 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

SEP 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1945, at 6:10 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured Sternum & ribs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 41

(a) Date of injury 9-8-45 at 11 P. M.

(b) Where did injury occur? 330 St. Paul Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.

(d) Means of injury Fall from 3rd story window

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed September 9, 1945.

G32244 AB-95129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 b

G32244 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER OR PRINTING WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-8days
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Warner St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Moore

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31- 1884

8. AGE: Years	Months	Days	If less than one day
61	1	8	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Moore
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Weldon
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13. 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location City of Baltimore

18 (a) Funeral director Joseph A. Lyerly
(b) Address 422 Mount Street

19 (a) (b) Huntington Williamsport Md
(Signature of local registrar)

SEP 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-8-1945 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31- 1945 to 9-8- 1945, and that I last saw h im alive on 9-8- 1945

Immediate cause of death Carcinoma of Stomach & Esophagus — Duration 13hrs

Due to Broncho pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/3/45

Major findings of operation: Carcinoma of Stomach & Esophagus

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Perry M D
Address B C H Date signed 9/9/45 M. D.

G32245 61 ✓ G32245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 W Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Holmes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife George W. Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1894

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	5	3		

9. Birthplace Baltimore County Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

MOTHER / FATHER
12. Name Thomas Talbott
13. Birthplace Baltimore Cnty Md
MOTHER
14. Maiden Name Henarett Hill
15. Birthplace Baltimore Cnty Md

16 (a) Informant George W. Holmes
(b) Address 905 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Annex
Location Baltimore City Md

18 (a) Funeral director Joseph A. Borky
(b) Address 400 N Mount St

19 (a) SEP 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to 9-7 1945 and that I last saw h— alive on 9/6 1945.

Immediate cause of death Diabetes Mellitus

Duration
9
mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1725 Pa Ave Date signed 9/10/45

VS 150

Huntington Williams, M.D.

G32246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1194

G32246 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4516 Hamanett Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Hanover

3 (a) FULL NAME Baby Boy Kruell

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-45

8. AGE: Years	Months	Days	If less than one day
	1	9 41	hr. min.

9. Birthplace Univ. Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name August Kruell
13. Birthplace Balto. Maryland

MOTHER
14. Maiden Name
15. Birthplace Balto.

16 (a) Informant Mr August Kruell
(b) Address 3817 Dona Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11, 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Garden No.

18 (a) Funeral director H. HEEMANN & SON
(b) Address 32 S. Broadway

19 (a) (Date rec'd by registrar) (b) Name of [illegible]

SEP 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31 1945 to 9-9 1945, and that I last saw h( ) alive on 9-9 1945

Immediate cause of death Prematurity
Infectious Diarrhea — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mabel E. Drake M.D.
Address Green & Redwood Date signed 9-9-45

X

G32247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87 2

G32247 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Nelson Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 2nd Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Erma D Williams

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Merl Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/1/02

8. AGE: Years	Months	Days	If less than one day
43	1	8	hr. min.

9. Birthplace Penn
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Grobich
13. Birthplace Penn

MOTHER
14. Maiden Name Carrie Masters
15. Birthplace Penn

16 (a) Informant Merl F. Williams
(b) Address 201 Second Ave - Lansdowne

17 (a) Removal (b) Date thereof Sept 10-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Scranton Penna

18 (a) Funeral director Edw A Taulson
(b) Address 359 Washington Blvd

19 (a) (b) Huntington Williams Mgr
Registrar

SEP 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1945, at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on 9/9 1945

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Malignant Hypertension	
Due to	
Other Conditions Hypertensive Encephalopathy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Raeth M.D.
Address St. Agnes Hosp Date signed 9/9/45

102

G32248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 Marshall Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Roxana Jane Nelson

3 (b) If veteran, name war: No

3 (c) Social Security Account No. No

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-45

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Woodrow Wilson Nelson
13. Birthplace Somerset, Colorado

MOTHER
14. Maiden Name Elva Jean Flacks
15. Birthplace Klamouth Falls, Oregon

16 (a) Informant Mrs. Elva Nelson
(b) Address 1826 Marshall Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 10-1945 (month) (day) (year)
(c) Cemetery or crematory Dudrow Pet
Location Pratt & B. M. Walker

18 (a) Funeral director Pratt & Shuster Co
(b) Address

19 (a) (b) Registrar
(State or local burial permit)

SEP 10 1945
VS 199

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1945 to 9-5 1945, and that I last saw her alive on 9-5 1945

Immediate cause of death: Congenital Atelectasis — Duration: 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobbie F. Cancer M. D.
Address Franklin Sq. Hosp. Date signed 9-6-45

X

PRINT OR TYPEWRITE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32249

HEALTH DEPARTMENT—CITY OF BALTIMORE

G32249

CERTIFICATE OF DEATH 131 b

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 E. Monument St. ✓ Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

If U. S. Veteran specify WAR

2. FULL NAME Lula Green 10

(a) Residence: No. 1302 E. Monument St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. Color or Race: Col

5. Single, Married, Widowed, or Divorced (write the word): Widowed

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr William Green

6. DATE OF BIRTH (month, day, year): 1880

7. AGE: Years: 65 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): North Carolina

FATHER

13. NAME: John Ford

14. BIRTHPLACE (city or town) (State or country): N. C.

MOTHER

15. MAIDEN NAME: M. Staden

16. BIRTHPLACE (city or town) (State or country): N. C.

17. INFORMANT: George Jarrett

(Address) 2166 Clinton ave N.J.

18. BURIAL, CREMATION, OR REMOVAL

Filed Burial Date 9/10 1945

Mt Calvary

19. UNDERTAKER: Elroy O. Wilson

(Address) 1000 Brantley ave

SEP 10 1945 19... Lucille Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Sept 6, 1945

22. I HEREBY CERTIFY, That I attended deceased from July 15, 1945 to Sept 6 1945

I last saw him alive on Sept 6 1945 Death is said to have occurred on the date stated above, at 9 3/4 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Nephritis	1 year
Other contributory causes of importance: Chronic Myocarditis	6 mo.

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ...

(Signed) Calvin B. LeCrew M. D.

(Address) 1113 N Caroline St

OCCUPATION is very important. See instructions on back of certificate. Exact statement of

V8 5

X

G32250

BALTIMORE CITY HEALTH DEPARTMENT 94 a

CERTIFICATE OF DEATH

Registered No. G32250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md. 9
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Normal Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles John Petri

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amelia Petri

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1891

8. AGE: Years 54 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business Carr-Lowry Glass Co

FATHER
12. Name George Petri
13. Birthplace

MOTHER
14. Maiden Name Fisher
15. Birthplace

16 (a) Informant Mrs. Amelia Petri
(b) Address 1613 Normal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Parkville Baltimore Co. Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) SEP 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 19 45 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walker M.D. Medical Examiner.
Date signed September 9, 1945.

G32251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a G32251
Registered No.

The information should be carefully supplied. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR TYPEWRITE, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2644 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELWOOD M. REIGHTLER

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 218-05-6260

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna E. Reightler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1894

8. AGE: Years 51 | Months 0 | Days 3 | If less than one day: hr. min.

9. Birthplace Wraverton, Md. (Town, county, and state)
10. Usual Occupation Riding Academy
11. Industry or business Self

FATHER
12. Name Wm. S. Reightler
13. Birthplace Md.

MOTHER
14. Maiden Name Tena Martin
15. Birthplace Thurmont, Md.

16 (a) Informant Mrs. Dorothy V. Bruchy
(b) Address 2644 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by local registrar SEP 10 1945 (b) Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1945, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Sept 7 1945, and that I last saw h[illegible] alive on Sept 7 1945.

Immediate cause of death: Lymphosarcoma. — Duration:
Due to: Arteriosclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. E. Reedle
Address 1314 - W. North St. Date signed 9/8/45

G32252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

951 G32252 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1921 Homewood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ratcliff

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Marvin T. Ratcliff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

MOTHER / FATHER
12. Name William Vick
13. Birthplace Baltimore, Maryland
14. Maiden Name Mary Krebs
15. Birthplace Germany

16 (a) Informant Mr. Marvin T. Ratcliff
(b) Address 1921 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill, Cemetery
Location Towson

18 (a) Funeral director WILLIAM J. TICKNER & SONS
(b) Address Baltimore, Maryland

SEP 10 1945

(a) Registrar (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/ 1945, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to 9-8- 1945
and that I last saw h[illegible] alive on 9-7-1945.

Immediate cause of death (a) Coronary Thrombosis — Duration 2 days
Due to Rheumatic Heart Disease — 15 yrs.
Due to Leukemia — 10 mos.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Solomon Sherman M. D.
Address 2424 Eutaw Place Date signed 9-10-45

+ Solomon Sherman

VS 150

G32253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G32253

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 W. North Ave.
(c) Hospital or institution:

15 1a

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. ALDOM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robert W. Aldom
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	16	hr. min.

9. Birthplace Mt. Savage, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Casey
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Webb
15. Birthplace Mt. Savage, Md.

16 (a) Informant Mrs. Ellen Rutter
(b) Address 2913 W. North Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Rosehill Cem.
Location Cumberland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 10 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1945 at 6:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 7 1945 to Sept 7 1945 and that I last saw her alive on Sept 6 1945

Immediate cause of death Respiratory failure

Due to Carcinoma of kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Shorofsky M D
Address 601 N. Monroe St Date signed 9/10/45 M. D.

VS 150

X

G32254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G32254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Weyworth Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Mendes.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 day | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesus Mendes
13. Birthplace Cuba

MOTHER
14. Maiden Name Arminta
15. Birthplace Cuba

16 (a) Informant Arminta Mendes Mother
(b) Address 2508 Weyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location German Hill Rd.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1437 E. Balto St

19 (a) SEP 10 1945 Huntington Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8, 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1945 to 9/9 1945 and that I last saw h[illegible] alive on 9/5 1945.

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G32255

BALTIMORE CITY HEALTH DEPARTMENT 1945

CERTIFICATE OF DEATH

Registered No. G32255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116½ Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116½ Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rita B. Arrington

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	—

6 (b) Name of husband or wife
6 (c) If alive, give age 19 years
7. Birth date of deceased (mo., day, yr.) Jan 27 - 1944

8. AGE: Years	Months	Days	If less than one day
1 3	7	9	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard T. Arrington
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Doris Blackstone
15. Birthplace Balto Md.

16 (a) Informant Doris Arrington
(b) Address 116½ Aisquith St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept. 10th 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Cahary
Location A. A. Co. Md.

18 (a) Funeral director Bryson Thomas & Inglis
(b) Address 721 Aisquith St

19 (a) SEP 10 1945 (Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 6 - 1945 at 11 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of 1st Cervical Vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-4- at 5-1 P. M.
(b) Where did injury occur? Playground Fayette & Augusta
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury? Struck by Swing

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-7-45

G32256

BALTIMORE CITY HEALTH DEPARTMENT 183

CERTIFICATE OF DEATH

G32256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1145 E. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hopkins (HOPKINS)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 14 1932

8. AGE: Years	Months	Days	If less than one day
13	2	23	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Henry Hopkins
13. Birthplace S. C.

MOTHER
14. Maiden Name Ethel McDuffie
15. Birthplace N. C.

16 (a) Informant Ethel M. Hopkins
(b) Address 1145 Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaac T. Burns
(b) Address 108 W Montgomery St

19 (a) (Date) SEP 10 1945 (Registrar) Washington Nicholas, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1945, at 3:29 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury 9-7- at 2.05 P. M.
(b) Where did injury occur? City Harbor, Ft. J Somerton Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning

23. Signature Howard J. Simmons M.D. Medical Examiner.
Date signed 9-8-45

Physicians: please write the causes of death clearly and legibly. The

G32257 146C G32257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Westwood Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Amelia A. Brooks

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex F | **5. Color or race** W | **6 (a) Single, married, widowed, or divorced.**

6 (b) Name of husband or wife Norman E Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 - 1902

8. AGE: Years 43 | Months 1 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Jaeger
13. Birthplace Md. Baltimore

MOTHER
14. Maiden Name Emma Jones
15. Birthplace Md. Baltimore

16 (a) Informant Mr. Norman Brooks
(b) Address 2907 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves Balto., Md.

(c) Registrar (b) Huntington Williams, M.D.

SEP 10 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1945, at 11 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 8 1945, and that I last saw h[illegible] alive on Sept 8 1945.

Immediate cause of death Cardiac failure — **Duration** 3 months

Due to Old rheumatic heart

Toxemia of pregnancy

Due to Pos. Acute Yellow Atrophy of Liver

Other Conditions Pregnancy, nearly at full term
(Include pregnancy within 3 months of death)

Major findings:
Of operations Hysterectomy for incontrolable post partum hemorrhage
Of autopsy

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Juan Noguera M.D.
Address Maryland Gen Hosp **Date signed** 9/8/45

M. D.

Head

Physicians: please write the causes of death clearly and legibly.

G32258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G32258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 410 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Lakeview Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar V. Levy (Edgar V. Levy)

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-8294

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1893

8. AGE: Years 52 Months 3 Days 23 Unless less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retailer

11. Industry or business

FATHER
12. Name Morris Levy
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Pfefferkorn
15. Birthplace Germany

16 (a) Informant Miss. Rena W. Levy
(b) Address 2737 Lakeview Ave

17 (a) Burial (b) Date thereof 9/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Chevra Shalom
Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place

19 SEP 10 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1945 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Jayne thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to D.O.A. death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/9/45

VS 151

G32259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G32259

The information requested on this certificate is necessary for the registration of the death. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Dr. and 31st Street
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND WILSON MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1911

8. AGE: Years	Months	Days	If less than one day
34	3	7	hr. min.

9. Birthplace Williamson, W. Virginia
(Town, county, and state)
10. Usual Occupation Welder--
11. Industry or business

FATHER
12. Name Sam Miller
13. Birthplace Athens, W. Va.

MOTHER
14. Maiden Name Jennie Wolford
15. Birthplace Kentucky

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Sept 13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Princeton W Va

18 (a) Funeral director Rice L Beyer Jr
(b) Address 15 1/2 Hillen St

19 SEP 10 1945 (b) Huntington Williamson W.Va.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1945, at 12:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 1945, to Sept. 9, 1945, and that I last saw him alive on Sept. 9, 1945.

Immediate cause of death	Duration
Perforated peptic ulcer with complications of peritonitis	4 da.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
Address US Marine Hospital, Baltimore, Md. Date signed 9/10/45 M D

VS 150

G32260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G32260

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Wyeth st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Wyeth st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Ervin
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-05-4301

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Carrie Ervin
6 (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) 6/4/1880

8. AGE: Years	Months	Days	If less than one day
65	23	4	hr. min.

9. Birthplace Balto co md.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

MOTHER FATHER
12. Name Isaac Ervin
13. Birthplace Balto co md.
14. Maiden Name Margret Lecill
15. Birthplace Balto Co md.

16 (a) Informant Carrie Ervin
(b) Address 502 Wyeth st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Wash. Blvd.
18 (a) Funeral director Ambrose J. Mead
(b) Address Franklintown
19 (a) SEP 10 1945 (b) Registrar
(Date rec'd by registrar)
Huntington Hillsman, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 8 1945
and that I last saw h alive on 19

Immediate cause of death	Duration
Odema of Lungs	48 hrs.
Due to	
Due to Generalized Arterio Sclerosis	3 yrs
Other Conditions Chronic Myocarditis (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. L. Lechtenberg
Address 708 E North Ave Date signed 9/10-45 M. D.

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32261

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32261
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME O'Berry Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1900

8. AGE: Years	Months	Days	If less than one day
45	8	4	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Willis Crawford
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachel Hamilton
15. Birthplace N. C. ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)
(c) Cemetery or crematory Goldsboro N. C.
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1417 E. Preston St.

(Date rec'd by registrar) (b) Registrar Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1945, at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1945 to Sept. 8 1945, and that I last saw him alive on Sept. 8, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	2 mo. t
Due to Sarc.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Pollock M. D.
Address 1515 E. Fayette St. Date signed 9-12-45

- 2 -

G32262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G32262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 744 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 744 W Fayette Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ilnia

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-7625

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 57 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph Ilnia
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Anna Ilnia
(b) Address 744 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Joseph Kaminska
(b) Address 602 Wash Blvd

(b) Huntington Williams, M.D. Registrar

SEP 10 1945 (Date received by Registrar)

VS 150 (OCR)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death Carcinoma of stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Ilnia M.D.

Address 3400 Hillon Rd Date signed 9/10/45

Approved: Robert Lee Taylor M.D. Sept. 10 1945

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 51 B

G32263 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eagle St
(c) Hospital or institution:
South Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Hudson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST ECHES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife ANNA M. ECHES
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 0 5 1 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimore (town, county, and state)
10. Usual Occupation Retired Policeman
11. Industry or business Chas. T. Brandt Steel Co.

FATHER
12. Name Conrad J. Eichenlaub
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A J Hermann
15. Birthplace Germany

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1637 N Broadway

19 (a) SEP 10 1946 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1946, at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1946 to 9/9 1946 and that I last saw him alive on 9/9 1946

Immediate cause of death	Duration
Pulmonary Embolus	
Due to Carcinoma of Prostate ?	
Due to Perforation Intest ?	
Duodenal Mell. ?	
Other Conditions Benign Prostatic Hyp ?	
Perineal Fistula ?	

(Include pregnancy within 3 months of death)

Date of operation 7/31/46
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy: C.A. of Prostate

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Madison Bledsoe M. D.
Address South Bal St Date signed 9/9/46

VS 150

X Hosp

G32264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G32264 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 E.North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 E.North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Viola F.Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Horace C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.21,1896

8. AGE: Years	Months	Days	If less than one day
49	0	18	hr. min.

9. Birthplace Phila.Pa.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Howard O.Lawrence
13. Birthplace Phila Pa.

MOTHER
14. Maiden Name Percilla Garrison
15. Birthplace Phila Pa.

16 (a) Informant Janice M.Manning
(b) Address Ferndale Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory St.Matthews
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) SEP 10 1945 (Date rec'd by registrar) (b) Huntington W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.8,1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/29 19 44 to 8/28 19 45 and that I last saw h alive on 19

Immediate cause of death Carcinoma of Cervix — Duration 2yr

Due to

Due to

Other Conditions Uremia — 6 WK

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William K Wiehl M.D.

Address 11 E Chase St Date signed 9/10/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32265

G32265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Orkney Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Orkney Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Frances Fitzsimons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John J. Fitzsimons | (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 2. 1870

8. AGE: Years 74 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

MOTHER / FATHER
12. Name Patrick Butler
13. Birthplace Ireland
14. Maiden Name Mary Sullivan
15. Birthplace Maryland

16 (a) Informant Mrs Joseph A Fitzsimons
(b) Address 518 Orkney Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Foley Sons
(b) Address 1218 Light St

19 (a) SEP 10 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/45 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1945 to 9/8 1945, and that I last saw h[er] alive on 9/7 1945.

Immediate cause of death Myocerebral Insufficiency — Duration 4 hours
Due to Arteriosclerosis — 6 mos
Due to Fractured Intertrochanteric — 1
Other Conditions Chronic Arthritis Deformans Parkinsonism Syndrome — 1
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. White
Address 592 S. 22nd St Date signed 9/10/45 M. D.

The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G32266 Cremeny G32266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 h

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5604 Magnolia Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5604 Magnolia Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James C. Cremen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1868

8. AGE: Years	Months	Days	If less than one day
77	1	13	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER

12. Name Robert Cremen

13. Birthplace Ireland

MOTHER

14. Maiden Name

15. Birthplace

16 (a) Informant James Cremen Jr

(b) Address 5604 Magnolia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month), (day), (year)

(c) Cemetery or crematory Druid Ridge

Location Balto. Co.

18 (a) Funeral director Martin Saby & Sons

(b) Address 1827 N. Howard St. Huntington Woods

1945 (Rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1941 to Sept 9 1945, and that I last saw h[illegible] alive on Sept 8 1945

Immediate cause of death

Duration

Congestive Heart failure 1wk

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Pulmonary TB

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. McAllen M. D.

Address 334 Fredrick Ave Date signed 9/9/45

VS 150

932

G32267 93d G32267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkins Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eaton & Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Lucilla Dunn

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife ✓ 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1864

8. AGE: Years	Months	Days	If less than one day
81	6	1	hr. min.

9. Birthplace Webster, Monroe Co. N.Y.
(Town, county, and state)
10. Usual Occupation Sister of Charity
11. Industry or business

FATHER
12. Name Thomas Dunn
13. Birthplace W. Meath, Ireland

MOTHER
14. Maiden Name Catherine Hughes
15. Birthplace New York City N.Y.

16 (a) Informant Hospital Records
(b) Address Eaton & Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Lafferty & Sons
(b) Address 1827 W. North Ave.

19 45 (b) Date rec'd by registrar Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1945, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19.
and that I last saw her alive on 9/7 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic arteriosclerosis	
Due to Cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Lovett Jr.
Address St. Agnes Hosp Date signed 9/9/45 M.D.

X

632268 Schofield 632268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 W Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George R Schofield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Anna Schofield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3rd 1890

8. AGE: Years	Months	Days	If less than one day
54	11	5	hr. min.

9. Birthplace Phila Pa. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Edward Joseph Schofield
13. Birthplace England

MOTHER
14. Maiden Name Emma Jane Cherry
15. Birthplace Florida

16 (a) Informant Mrs Edna Wander
(b) Address Mt Holly N.J.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) Date rec'd by Registrar 9 11 1945 (b) Washington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1945, at 5 06 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage, spontaneous

Due to Ruptured aneurysm of Anterior Cerebral Artery

~~Other Conditions~~

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D. Medical Examiner.
Date signed Sept 10 1945

G32269

BALTIMORE CITY HEALTH DEPARTMENT 92 ✓ Registered No. G32269

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Rosedale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. J. Hobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Emma J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3. 1876

8. AGE: Years 69 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Painter Retired

11. Industry or business

FATHER
12. Name Edwin R. Hobbs
13. Birthplace Md

MOTHER
14. Maiden Name Mary Hampton
15. Birthplace Md

16 (a) Informant Emma J. Hobbs
(b) Address 607 Rosedale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Eyler
(b) Address 1217 E Lombard St

EP (a) 11 1945 (Date rec'd by Registrar) (Name) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945, at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Sept 7 1945 and that I last saw h[illegible] alive on Sept. 7 1945.

Immediate cause of death Cerebral hemorrhage Duration one day

Due to arterio sclerosis

Chronic endocardial (mitral regurgitation) and myocardial disease.

Other Conditions with contributing enlargement and congestive failure.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 701 Edmondson Ave Date signed Sept 8 45

VS 150

83a

322270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. G322270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 N. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Vetters

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Vetters
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1876

8. AGE: Years 69 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Watchman (Retired)
11. Industry or business

FATHER
12. Name William Vetters
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eliza Corney
15. Birthplace Baltimore, Md.

16 (a) Informant Mary A. Vetters
(b) Address 301 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Md Lorraine Mt

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/45, 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Sept 1945 and that I last saw him alive on 9/7 1945.

Immediate cause of death Hypertensive Cardio-Vasc. Disease — Duration
Due to Chronic Nephritis
Due to
Other Conditions Uremia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Pound
Address 400 N. Payson Date signed 9/10/45

Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

VS 189

G32271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G32271

Type or print with UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Remington Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Laura V. Barnes

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband Millard F. Barnes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1873
8. AGE: Years 72 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name James Atkinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Laura "
15. Birthplace "

16 (a) Informant Lila Barnes
(b) Address 2911 Bagonne Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 217 St. Paul St
SEP 11 1945 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 4 45 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1945 to Sept 10 1945 and that I last saw h alive on Sept 10, 45

Immediate cause of death — Duration
(a) Chronic Myocarditis — Indefinite
Due to
Due to
Other Conditions Arteriosclerosis — Indefinite
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Estelle Andrews M.D.
Address 112 W. 25 St Date signed Sept 10, 45

VS 150

$15775 G32272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312 ✓ G32272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 White Chapel Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anne Kramer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Harry Kramer
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 4 - 3 - 1914

8. AGE: Years	Months	Days	If less than one day
31	5	7	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Samuel Kramer
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant recess
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-45 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tfiloh
Location Wyndon Mall Rd

18 (a) Funeral director Jack Levin-Shy
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

SEP 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945 at 7 21 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1945 to 9-10 1945; and that I last saw h Her alive on 9-10 1945.

Immediate cause of death	Duration
Azotemia - Uremia	approx 2 mo.
Cachexia	
Due to Chronic Glomerulo - Nephritis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Jackson M.D. M. D.
Address Johns Hopkins Hospital Date signed 9/12/45

IMPORTANT—FILL IN ALL ITEMS CAREFULLY AND LEGIBLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d ✓ Registered No. G32273

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 RD. & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL 9 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 VENABLE AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MRS. HELEN L. SHEARER (SHEARER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MR. SPENCER R. SHEARER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 12, 1900

8. AGE: Years	Months	Days	If less than one day
45	0	28	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name EMMANUEL CHRISSINGER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name BERNIE MADDEN
15. Birthplace VIRGINIA

16 (a) Informant Spencer R. Shearer.
(b) Address 604 Venable ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor ave

18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road.

SEP 11 1945 (Date received by Registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 9 1945, at 4:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 18 1945, to SEPT 9 1945, and that I last saw her alive on SEPT 9 1945.

	Duration
Immediate cause of death MYOCARDIAL INFARCTION	
Due to GENERALIZED ARTERIOSCLEROSIS	
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	
Other Conditions CEREBRAL HEMORRHAGE	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Shearer III
Address Union Memorial Hospital Date signed 9/9/45

X

Zench

G32274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137B

Registered No. G32274

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1902 h Wolfe Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5

(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore 13 Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 1902 h Wolfe Street (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Karl K Zench

3 (b) If veteran, name war: ha

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowers

6 (b) Name of husband or wife: Johanna Zench

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1864

8. AGE: Years 81 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER

12. Name Wilhelm Zench

13. Birthplace Germany

MOTHER

14. Maiden Name Katherine Schlhase

15. Birthplace Germany

16 (a) Informant Mrs Joseph Zench

(b) Address 190 h Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Baltimore, Maryland

18 (a) Funeral director Albert L Stiffler

(b) Address 1606 h Chester St

19 SEP 11 1945 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1945, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1945 to Sept. 9 1945, and that I last saw him alive on Sept. 9 1945

Immediate cause of death Bronchopneumonia. — Duration 24 hrs

Due to

Due to

Other Conditions Prostatitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Novak M. D.

Address 101 W. Read St Date signed 9-11-45

VS 150

107

G32275

HEP #95376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1361

Registered No. G32275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Kinsey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Earl Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1889

8. AGE: Years	Months	Days	If less than one day
55	10	22	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Fletcher (d)
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth (d)
15. Birthplace Ohio

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery Location

18 (a) Funeral director
(b) Address

19 (a) SEP 11 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1945, at 6:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11, 1945, to Aug. 30, 1945, and that I last saw him alive on August 30, 1945.

Immediate cause of death	Duration
Uremia ?	
Due to urinary tract infection	
Due to	
Other Conditions Anemia and cachexia (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Haviland M. D.
Address DEH Date signed 9/6/45

UNIVERSITY MEDICAL SCHOOL SEP 7 1945

2936

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G32276

G32276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

JO #95755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Homeless (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sam Pisano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?1875

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unable to obtain information.
13. Birthplace " " " "

MOTHER
14. Maiden Name " " "
15. Birthplace " " " "

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1945, at 1:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29, 1945, to Aug. 31, 1945, and that I last saw him alive on Aug. 30, 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions congestive heart failure (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Rowland M. D.
Address BCH Date signed 9/6/45

VS 150

2937

×

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G32277

JO #46589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs 1mo 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wehrhahn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Separated

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1869

8. AGE: Years	Months	Days	If less than one day
76	-3-	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Edward
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Weber
15. Birthplace Baltimore, Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1945, at 6:35PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1939, to Aug. 31, 1945, and that I last saw him alive on Aug. 31, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 Day.
Due to
Due to
Other Conditions Arteriosclerosis — 6 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Woodward M. D.
Address Baltimore City Hospitals Date signed 9-6-45

VS 150

2938

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32278

HEP #94481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 L

Registered No. G32278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 & 21
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1906

8. AGE: Years	Months	Days	If less than one day
38	8	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathaniel Edwards (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Washington (D)
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 1 1 1945 (Date rec'd by Registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1945, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 1945 to Aug. 23, 1945, and that I last saw h im alive on Aug. 23, 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Greland Jr. M. D.
Address Balt. City Hosp. Date signed 8/31/45

VS 150

2939

X

...WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

632279 HRP #67524 96 Registered No. 632279

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -4 & 8
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Market Space, Lodging House (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	3	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Stewart
13. Birthplace Scotland

MOTHER
14. Maiden Name Helen McFadden
15. Birthplace Scotland

16 (a) Informant Baltimore City Hospitals Record
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 4 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1945, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19, 1945 to Aug. 27, 1945, and that I last saw him alive on Aug. 27, 1945.

Immediate cause of death Ruptured abdominal aortic aneurysm

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address JHCH Date signed 8/31/45

VS 150

2940 X

G32280 ✓ G32280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 h

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Mc Henry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Mc Henry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Griest

3 (b) If veteran, name war

3 (c) Social Security Account No 218-09-9354

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Rose Zimmerman Mc Kenzie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto. Transit Co.

FATHER
12. Name — Griest
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Rose Griest
(b) Address 1419 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.12.45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Maryland

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntingdon Williams, M.D. Registrar

SEP 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 3.A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1944 to Sept. 10, 1945, and that I last saw h. alive on Sept 9 1945.

Immediate cause of death Metastasis from Ca. of Prostate gland — Duration 11 mo.

Due to Carcinoma of Prostate Gland — 440

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Coleman Rigdon M. D.
Address 2424 Eutaw Place Date signed 9-10-45

X

IMPORTANT. WRITE WITH PEN AND INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G32281

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Q.I.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Jasper St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1945, at 6 25 P M

21. I certify that I took charge of the remains described above, held an Autopsy Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubrinski M.D.
Medical Examiner.
Date signed 9/12/45

2941

G32282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 b

Registered No. G32282

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 552 N. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 1 1945 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

2942

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1945 at 8:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelizzola M.D.
Medical Examiner.
Date signed 8/31/45

X

G32283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G32283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Coldspring Lane
(c) Hospital or institution: Coldspring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Hinchman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation None
11. Industry or business Retired

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL SEP 6 1945
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 11 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1945, to Aug 24 1945, and that I last saw him alive on Aug 21 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Spontaneous, ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Butterman M.D.
Address 2324 Reisterstown Rd Date signed 8/24/45

VS 150

2943 Howard J. Bluestein, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32284

Void

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

Registered No. G32284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Light St.
(c) Hospital or institution: Sinai Hosp. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Pittsburgh Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOHN B. BEALEFELD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife LILLIAN C. BEALEFELD 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1901

8. AGE: Years	Months	Days	If less than one day
44	7	0	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Policeman
11. Industry or business

FATHER
12. Name Barney Bealefeld
13. Birthplace Maryland

MOTHER
14. Maiden Name Mamie East
15. Birthplace Maryland

16 (a) Informant Lillian C. Bealefeld
(b) Address 2610 Pittsburgh Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. G. Co. Md.

18 (a) Funeral director Mrs. Mrs. John M. Teufel & Son
(b) Address 801 N. Fayette St

19 (a) 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1945 to Sept 10 1945, and that I last saw him alive on Sept 9 1945.

Immediate cause of death: Fat Embolus — Duration: 2 Days
Due to
Due to
Other Conditions Cyst Fat. Left Fibula Fibula
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Homicide
(b) Date of occurrence 8-30-45 at 10:15 PM
(c) Where did injury occur? 1526 Boyle St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? yes
(e) Means of injury Pushed down steps.
23. Signature John Madison Bealefeld III M.D.
Address Sinai Hosp. Gen. Date signed 9/10/45

VS 150

Approved: Chester J. Lubinski M.D. Hosp Coroner's Physician M.D.

G32285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314

G32285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 Burnett St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Burnett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Stockler

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Stockler

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec 13/1884

8. AGE: Years 55 Months 8 Days 27 If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Charles B. Grisp

FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Anna Sarau

MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Joseph Stockler

16 (b) Address 125 Burnett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12. 1945 (month) (day) (year)

17 (c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs Mrs. John W. Teufel & Son

18 (b) Address 801 W Fayette St.

19 (a) SEP 11 (Date rec'd by registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1945 at 4.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to Sept 9 1945 and that I last saw h alive on Sept 9 1945

Immediate cause of death

Acute Dilatation of Heart — Duration 2 days

Due to Chronic Nephritis — Duration 2 Mo 9 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. E. Campbell Coroner M. D.

Address Sept 10/45 Date signed

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32286 ✓ G32286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street Address 4413 Liberty Heights Ave.

(c) Hospital or institution: Alberta Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-27

(e) Length of stay in Baltimore (yrs., mos., or days) 55 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1463 Reynolds St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Doegen SR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-4343A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced	6 (b) Name of husband or wife	6 (c) If married, widowed, or divorced, how long	7. Birth date of deceased (mo., day, year)	8. AGE: Years	Months	Days	If less than one day: hr.	min.
M.	White	Widower	Matilda	years	July 27 - 1861	84	1	18		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Bethlehem Steel

FATHER

12. Name Not Known

13. Birthplace Germany

MOTHER

14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant Chas Doegen Jr.

(b) Address 123 N. Eldwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Rd

18 (a) Funeral director Geo H. Kembrach

(b) Address 725 N Eutaw St.

19 (a) Date received by local registrar SEP 11 1945 (b) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1945, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944, to Sept. 9 1945, and that I last saw h[illegible] alive on 19

Immediate cause of death Cerebral Thrombosis — Duration 13 mos.

Due to Generalized arteriosclerosis — ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury —

23. Signature M. Bokeiter M. D.

Address 54 S. Fulton Ave. Date signed 9-10-45

G32287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1033 Somerset
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 Somerset
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mc Eachin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-45

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Mc Eachin
13. Birthplace Yoke County - Va.

MOTHER
14. Maiden Name Ethel Mae Winston
15. Birthplace York Co. Va.

16 (a) Informant Ethel Mae Mc Eachin
(b) Address 1033 Somerset

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 11 1945 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1945 at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1945 to 9-5-1945 and that I last saw h— alive on 9-5-1945

Immediate cause of death malnutrition

Due to Premature birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Berry M. D.
Address 1420 E. Chase Date signed 9-5-45

VS 150

2944

G32288

Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 East St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Ferguson.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/45

8. AGE: Years	Months	Days	If less than one day
	3	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Roland A. Ferguson
13. Birthplace Md.

MOTHER
14. Maiden Name Edith 2.
15. Birthplace 2 2

16 (a) Informant M Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 10 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 11 1945 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 2 - 1945, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 to 19
and that I last saw her alive on 9/2 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Malnutrition	
Due to	
Other Conditions prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Hammond
Address JHH Date signed 9/4/45

VS 150

Signed: Robert L. Baker M.D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE HERE, WITH UNFADING INK.

G32289 479315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G32289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Barnett Lane
(If rural give location)
(e) Citizen of foreign country? Born in U.S.A. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Heiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-81

8. AGE: Years	Months	Days	If less than one day
64	6	5	hr. min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eliass Heiss
13. Birthplace Ky.

MOTHER
14. Maiden Name Katherine ? ?
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 1 1 1945 (b) Received by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1945, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1945 to Aug. [illegible] 1945, and that I last saw [illegible] alive on Aug. 27 1945.

Immediate cause of death Pneumonia with circulatory collapse. — Duration

Due to Strangulated Inguinal Hernia, Urethral Stricture.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 25 August 1945

Major findings of operation: Strangulated Inguinal Hernia - Right

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hospital Date signed

VS 150

2946

21 August 1945

Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITER, WITH UNFADING INK.

G32290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32290 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St. 13

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 dys 5½ wks

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2411 Madison Ave.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Harry T. Pratt

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Lavalette Pratt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1875

8. AGE: Years 69 | Months 10 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation Teacher (retired)

11. Industry or business —

FATHER 12. Name Louis Pratt

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Clara Smith

15. Birthplace Maryland

16 (a) Informant Hospital Record.

(b) Address

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Baltimore Co.

18 (a) Funeral director L. Preston Lamberg

(b) Address 519 Mosher St, Balto, Md.

19 (a) SEP 11 1945 (Date received by local registrar) (b) Huntingtown, Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1945, at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1945 to 9/8 1945, and that I last saw him alive on 9/8 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardio-vascular Disease	1 yr.
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Leary M. D.

Address Date signed

G32291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 539 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Mary Gottwaldt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Charles Gottwaldt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1876

8. AGE: Years 69 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business home

MOTHER / FATHER

12. Name Michael Reynolds

13. Birthplace Ireland

MOTHER

14. Maiden Name Catherine Flanagan

15. Birthplace Ireland

16 (a) Informant Mrs. Mary C. Trautwein

(b) Address 394 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1945 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Colgate Md

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) (b)

SEP 11 1945

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1945, to 9/9 1945, and that I last saw h[illegible] alive on 9/8 1945

Immediate cause of death myocardial insufficiency — Duration 7 days

Due to carditis — ?

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Schilad

Address 447 N. Kenwood Ave. Date signed 9/9/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The [illegible] WITH UNFADING INK.

JL G332292 G332292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G32292

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Washington St- Halethrope
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Sewell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife Herman (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1901

8. AGE: Years	Months	Days	If less than one day
44	0	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Benjamin Mitchell
13. Birthplace ?

MOTHER
14. Maiden Name Mary Bruce
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Maryland

18 (a) Funeral director Sollenberger Halstead
(b) Address 978 Reed Hill Ave.

19 (a) Sept 11 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1945, at 3:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25, 1945 to Sept. 9 1945, and that I last saw h. er alive on Sept. 9 1945.

Immediate cause of death	Duration
Carcinoma of breast with metastasis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy adenocarcinoma breast with general metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Baltimore Md. Date signed 9/11/45

VS 450

G32293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157

Registered No. G32293

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor Ave + Dukeland St

(c) Hospital or institution West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Balto. #21 Essex

(If outside city or town limits, write RURAL and give town)

(d) Street No. 14B. Westray North, Rivendale Apts

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 - 1945

8. AGE: Years | Months | Days | If less than one day hr. 15 min.

9. Birthplace West Balto. Gen. Hosp.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Raymond Walter Smith

13. Birthplace Honolulu

MOTHER

14. Maiden Name Stella Iris Shelton

15. Birthplace Marshall N.C.

16 (a) Informant Raymond Walter Smith

(b) Address 14B Westray North, Rivendale Apts

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 10 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1945, at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945, to 9/9 1945, and that I last saw h[illegible] alive on 9/9 1945

Immediate cause of death Atelectasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. Silverfeld M.D.

Address West Balto. Gen. Hosp. Date signed 9/9/45

VS 150

2947

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE ACROSS, WITH UNFADING INK.

G32294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G32294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital. 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 S. Sharp St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Blagman d.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-45

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James
13. Birthplace md.

MOTHER
14. Maiden Name Thelma Pinkney
15. Birthplace md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 8 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 11 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-45 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1945, to 8-29 1945, and that I last saw h[illegible] alive on 8-29 1945.

Immediate cause of death Prematurity

Duration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nate E Dade, MD M. D.
Address Univ. Hosp. Date signed 9-5-45

VS 150

2948

G32295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32295 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Union Memorial Hospital 15 W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d

(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3908 Duvall ave, City 16. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Julius E.E. Berndt

3 (b) If veteran, name war — none

3 (c) Social Security Account No. ? none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh.	widowed ?

6 (b) Name of husband or wife Susie Melchers Berndt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	20	hr. min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Retired

11. Industry or business Food Broker

FATHER 12. Name Ernest Berndt

13. Birthplace Germany

MOTHER 14. Maiden Name ? Knepel

15. Birthplace Germany

16 (a) Informant Mr. Carroll M. Berndt

(b) Address Franklin & Melanchton Aves, Lutherville

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Mem. Gdns.

Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Fichner & Sons

(b) Address Balto., Md.

19 (a) SEP 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10- 1945, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1945 to Sept 10 1945.

and that I last saw h[illegible] alive on Sept 10 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Arterl. C.V.D.,	
Due to Generalized arterio-sclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Basil O'Ruark M. D.

Address U. M. H. Date signed 9-10-45

VS 180

G32296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 d

Registered No. G32296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Richmond
(If outside city or town limits, write RURAL and give town)
(d) Street No. Westwood apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Murray M. McGuire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Clem Beck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1872

8. AGE: Years 73. Months 7 Days 21 If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Lawyer
11. Industry or business Self

FATHER
12. Name John P. McGuire
13. Birthplace Va

MOTHER
14. Maiden Name Clara Mason
15. Birthplace Va

16 (a) Informant Hosp. records
(b) Address

17 (a) Removal (b) Date thereof 9/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hollywood
Location Richmond, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 11 1945 (b)
(Date received by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-1945 at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10-1945 to 9-10-1945 and that I last saw him alive on 9-10-1945

Immediate cause of death Pulmonary edema - acute

Due to Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shifflett M. D.
Address Funeral Home & Hosp. Date signed 9-10-45

Huntington Williams, M.D.

The ~~G32296~~, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G32297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Morton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Mae Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Commodore P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6-1903

8. AGE: Years	Months	Days	If less than one day hr.	min.
41 Yrs	10	4		

9. Birthplace Lickingville, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Chas. Henry Myers
13. Birthplace Rockland Township

MOTHER
14. Maiden Name Elizabeth Beck
15. Birthplace Knox, Pa.

16 (a) Informant Miss Gloria Brown
(b) Address 1908 Morton St.

17 (a) Removal (b) Date thereof 9/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Tildiouty Pa.
Location Tildiouty Pa. R.D. Route 2

18 (a) Funeral director Wm J. Nelson & Son
(b) Address Balto., Md.

SEP 11 1945
(Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 7:55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest.
Fracture of Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 9, 1945 2:40 P.M.
(b) Where did injury occur? Howard & Franklin Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury auto into army ambulance

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 9-11-45

VS 151

Willie Van Judd

G32298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 L

Registered No. G32298

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline Ave.

(c) Hospital or institution St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1716 N. Caroline St. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Willie Van Judd

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-4778

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Blck	M.

6 (b) Name of husband or wife Mrs. Mattie Van Judd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/20

8. AGE: Years	Months	Days	If less than one day: hr.	min.
25	6	23		

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER

12. Name Garland Van Judd

13. Birthplace N. C

MOTHER

14. Maiden Name Rosa Heart

15. Birthplace N. C

16 (a) Informant Mattie Judd

(b) Address 1218 N. Caroline St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/4/45 (month) (day) (year)

(c) Cemetery or crematory

Location Sanford N. C.

18 (a) Funeral director Robert L. Young

(b) Address 804 N. Caroline St.

SEP 11 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/45 19 at 5:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/45 19 to 9/9/45 19, and that I last saw him alive on 9/9/45 19

Immediate cause of death Acute Cardiac failure

Due to Rheumatic heart

Due to disease - mitral

Other Conditions Stenosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Tom H. Rodgers M. D.

Address St. Joseph's Hosp. Date signed 9/9/45

G32299 G32299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1194

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 S. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence L. Woodward

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) FEB. 2 1945
8. AGE: Years | Months: 6 | Days: 8 | If less than one day: hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name CLARENCE WOODWARD
13. Birthplace S.C.

MOTHER
14. Maiden Name SOPHIE LEPKOWSKI
15. Birthplace BALTO. MD.

16 (a) Informant SOPHIE WOODWARD (MOTHER)
(b) Address 625 BOND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 13/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. WOLFE ST.

19 (a) SEP 11 1945 (Date received by local registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1945, at 7 45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Lentz M.D. (Medical Examiner)
Date signed Sept 10 1945

VS 151

G32300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52h

Registered No. G32300

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (MICHAEL) Michael Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-75

8. AGE: Years	Months	Days	If less than one day
70.	3	8	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Insurance Business

11. Industry or business

FATHER 12. Name Henry Kramer

13. Birthplace Russia.

MOTHER 14. Maiden Name Bessie Lehr

15. Birthplace Russia

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)

(c) Cemetery or crematory Balt-Hebrew

Location City

18 (a) Funeral director David Goodheim & Son

(b) Address 1902 Eutaw Pl

19 SEP 11 1945 Thurlington Williams

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept - 10 1945 at 10.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 24 1945 to Sept 10 1945 and that I last saw him alive on Sept - 10 1945.

Immediate cause of death	Duration
Carcinoma of bladder	10 yrs.
Failure and Renal insufficiency	
Due to Extensive	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert S. Donohue M. D.

Address Johns Hopkins Hosp Date signed 9-10-45

VS 150

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. TYPEWRITER, WITH UNFADING INK.

G32301 G32301

HEP #95637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Hickory Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John E. Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Nov 13 1870~~ 1876

8. AGE: Years	Months	Days	If less than one day
68 ~~99~~	9	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charlie John Parks
13. Birthplace Md.

MOTHER
14. Maiden Name Aducy Steinberger
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1945 (month) (day) (year)
(c) Cemetery or crematory Mays Chapel
Location Cathedral Mts (Ref)

18 (a) Funeral director Landon M. Bamb
(b) Address Sparks, Md.

19 (a) (b)

SEP 11 1945

Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1945, at 9:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1945 to Sept. 10, 1945, and that I last saw him alive on Sept. 10, 1945.

	Duration
Immediate cause of death Acute left ventricular failure	3 days
Due to Hypertensive cardio-vascular disease	yrs?
Due to	
Other Conditions Benign prostatic hypertrophy with retention (Include pregnancy within 3 months of death)	
Date of operation 9-6-45	
Major findings of operation: Benign prostatic hypertrophy Pulmonary	
Autopsy: embolism	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Orell M. D.
Address Balto City Hospitals Date signed 9-11-45

VS 150

G32302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32302

77E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Forge Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Lambert

3 (b) If veteran, name war no

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ernest Lambert

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1909

8. AGE: Years 35 35 | Months 11 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George H. Rogers
13. Birthplace Balto. Co., Md

MOTHER
14. Maiden Name Mary Duvall
15. Birthplace Balto. Co., Md.

16 (a) Informant Ernest Lambert
(b) Address 1423 Forge Ave, Balto, Md

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept 14 1945 (month) (day) (year)
(c) Cemetery or crematory Jessops
Location Sparks, Maryland

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) SEP 11 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Heart Failure

Due to

Other Conditions Hurting & alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Patterson M.D. Medical Examiner.
Date signed Sept 10 1945

G32303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163B

Registered No. G32303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New York County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Straus

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 578-26-8878

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife: Friedel Straus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	18	hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Ex-soldier

11. Industry or business

FATHER
12. Name: Oscar Straus
13. Birthplace: Vienna, Austria

MOTHER
14. Maiden Name: Clara Singer
15. Birthplace: Vienna, Austria

16 (a) Informant: Friedel Straus
(b) Address: 50 E. 78th St, N.Y.C, N.Y.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 13 1945 (month) (day) (year)
(c) Cemetery or crematory: New York City
Location: New York

18 (a) Funeral director: Ellsworth Advance
(b) Address: 3911 Liberty Heights Ave.

19 (a) SEP 11 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10 1945 at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute barbiturate poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 4-1

(a) Date of injury Sept. 9 1945 ? M.
(b) Where did injury occur? Enmon Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel ... While at work? No
(d) Means of injury: Swallowed Phenadorm pills

23. Signature: Robert Lee Gratam M.D. Medical Examiner.
Date signed Sept. 11 1945

Handling for Milwaukee Mo

G32304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G32304 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPE OR WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 East Chase St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Frederick Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian Kelly Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1882

8. AGE: Years	Months	Days	If less than one day
63 yrs.	7 mos.	20 days	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Hardware

FATHER
12. Name Ernest F. Schwartz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Helen Nickel
15. Birthplace Baltimore

16 (a) Informant Mrs. Lillian K. Schwartz
(b) Address 11 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 605 N. Calvert St.

19 (a) Filed by me SEP 11 1945 Huntington Mills, Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1945 at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1945 to Sept. 9 1945 and that I last saw him alive on Sept. 9 1945.

Immediate cause of death	Duration
Myocardial failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 9-9-45

G32305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V108 [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Thompson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1945

8. AGE: Years | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walton Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Leona Rasinski
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 1119 Hanover St.

17 (a) S. (Burial, cremation, or removal) (b) Date thereof 9-13-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn, Md.

18 (a) Funeral director J. H. McCauley
(b) Address 120 S. Charles

19 (a) (Date received by Local Registrar) SEP 11 1945 (b) Registered No. Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Sept 10 1945 and that I last saw h[illegible] alive on Sept 10 1945

Immediate cause of death	Duration
Pneumonia	2 days
Due to	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Bolick M. D.
Address 1213 Light St Date signed 9-13-45

X

PRINT, WRITE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 196

G32306

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William F. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife: Julia Mae Smith - Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: OUTSIDE HAND

11. Industry or business: BETH. STEEL CO

FATHER
12. Name: WM T SMITH
13. Birthplace: NORTH CAROLINA

MOTHER
14. Maiden Name: SADIE BRITT
15. Birthplace: VIRGINIA

16 (a) Informant: MRS. JULIA M. JOHNSON
(b) Address: 1613 N. APPLETON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)
(c) Cemetery or crematory: LOUDON PARK
Location: BALTO.

18 (a) Funeral director: MARY M. WIEDEFELD
(b) Address: 501 EAST 22ND STREET

19 SEP 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1945, at 3:45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intracranial Hemorrhage, apoplexy

Due to: Ruptured Aneurysm of cerebral artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Gratton M.D. Medical Examiner.
Date signed Sept. 10 1945

VS 151

G32307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 37

G32307 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 E Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 E. Biddle Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie (Anna) Karl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Joseph (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1878

8. AGE: Years	Months	Days	If less than one day
67	7	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Schlee
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Edward Karl
(b) Address 1024 Chesaco Avenue

17 (a) Burial (b) Date thereof 9/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (b) Hunting for Williams, M.D. Registrar

SEP 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945 at 12:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept 10 1945, and that I last saw him alive on Sept 10 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	2 days
Due to Arterio-Sclerotic-Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. M. Baumgardner M. D.
Address Balto 6 Md. Date signed 9/10/45

X

G32308 G32308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith Street
(c) Hospital or institution:
Convent of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Austria

3 (a) FULL NAME Sr. M. Wereburga Fritzel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 13, 1873

8. AGE: Years 72 Months 4 Days 27 If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name John Fritzel
13. Birthplace Austria

MOTHER
14. Maiden Name Helen Yalen
15. Birthplace Austria

16 (a) Informant Sisters of Notre Dame
(b) Address 901 Aisquith

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13/45 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) (Date rec'd by registrar) SEP 14 1945 (b) Huntington Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 5.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1939 to Sept. 10, 1945, and that I last saw her alive on Sept. 10, 1945.

Immediate cause of death Coronary thrombosis

Due to Nephritis - Hypertension

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. J. Storby

Address 1108 North Ave Date signed 9/14/45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT PLAINLY, WITH UNFADING INK.

G32309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32309 Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 E. Baltimore st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 E. Baltimore st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Spencer
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, ~~or divorced~~ Widowed
6 (b) Name of husband or wife George W Spencer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25 1880
8. AGE: Years 64 65 | Months 11 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Joseph A Peters
FATHER 13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Susana Hebling
MOTHER 15. Birthplace Baltimore Md

16 (a) Informant Chas. Spencer
(b) Address 2812 E. Baltimore st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12th (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore st
19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 45 to Sep 8 45 and that I last saw h alive on Sep 8 45

Immediate cause of death: Diabetes. Hypertension

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Insley M. D.
Address 2736 E Balt Date signed 9-10-45

SEP 1 1945

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G32310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. Altamont Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Goldsborough Hammond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1860

8. AGE: Years	Months	Days	If less than one day
85	3	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Charles H. Hammond
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Julia Johns
15. Birthplace Balto. Md.

16 (a) Informant Mrs. H. J. Hammond
(b) Address 1402 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill, Location Easton, Md.

18 (a) Funeral director John D. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) Filed by registrar 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1945, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 - 1945, to Sept. 9 1945 and that I last saw h[illegible] alive on Sept. 9 1945

Immediate cause of death — Duration

Due to Cerebral Hemorrhage

Due to Adv. Arteriosclerosis

Other Conditions Chr. nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Lasch M. D.
Address 1700 Eutaw Place Date signed 9-10-45

VS 150

X

G32311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G32311
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere ave + Greenspring ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 11 17
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere ave + Greenspring ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bernstein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Late Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Baer Rosenberg.
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam ?
15. Birthplace Russia

16 (a) Informant Paul Berman.
(b) Address 9513 Fairmont ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cemetery
Location 3609 E Balto St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) SEP 11 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Sept 11 1945 and that I last saw h.. alive on 9-11 1945.

Immediate cause of death: Coronary thrombosis. Hypertension.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund Levin
Address Levindale Date signed 9/11/45

VS 130

X

Numbers WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G32312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted] yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry Hoffman
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Katie Hoffman
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) July 15, 1891
8. AGE: Years 54 | Months 7 | Days 26 | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Business

FATHER
12. Name Hyman Hoffman
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie Hoffman
15. Birthplace Russia

16 (a) Informant Mrs. Katie Hoffman
(b) Address 4415 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Rd
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1126-26 W. North ave

19 (a) 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11/45 1945, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9/45 1945 to 9/11 1945 and that I last saw him alive on 9/10 1945.

Immediate cause of death Peripheral circulatory collapse & Ruptured Esophageal Varices
Due to Cirrhosis of Liver
Due to
Other Conditions Ascites
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S. Rottenberg M.D.
Address Sinai Hospital Date signed 9/12/45

Huntington Hillcrest Mfg. Co.

VS 190

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32313
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Linthicum Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Giles

3 (b) If veteran, name war

3 (c) Social Security Account No. 243-09-5815

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lutie E Giles
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.) Aug 23 1889

8. AGE: Years 56 | Months - | Days - 18 | If less than one day hr. min.

9. Birthplace Dorsey Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Contractor at Camp Meade

FATHER
12. Name Charles H Giles
13. Birthplace Butts Md

MOTHER
14. Maiden Name Mary Sharkey
15. Birthplace Butts Md

16 (a) Informant Mr Wm F. Giles
(b) Address Hammonds Ferry Rd Linthicum Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13-45 (month) (day) (year)
(c) Cemetery or crematory Zion Cemetery
Location Dorsey Md

18 (a) Funeral director Milton Schilling
(b) Address 3944 S. Hanover St 25

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

P 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 1:40 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dain death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest, Multiple Fractures of leg, right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 10, 1945 1:30 P. M. a.a. 60. P.
(b) Where did injury occur? Camp Meade Rd & Laurel Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Passenger in auto into fixed object

23. Signature Robert Lee Fraker M.D.
Medical Examiner.
Date signed 9-11-45

VS 151

G32314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G32314 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Sunderland
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Joseph Robert Lyons

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18 - 1930

8. AGE: Years	Months	Days	If less than one day
14	9	11	24 hr. min.

9. Birthplace Sunderland, Md.
(Town, county, and state)
10. Usual Occupation Schoolboy
11. Industry or business -

FATHER
12. Name
13. Birthplace Sunderland, Md.

MOTHER
14. Maiden Name Mildred Ward
15. Birthplace Maryland

16 (a) Informant father
(b) Address Sunderland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location All Saints Md.

18 (a) Funeral director Wm. H. Hutchins
(b) Address Owings Md.

SEP 12 1945 (b) [illegible] Registrar

VS F 2040

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 19 45, at 12.55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 19 45 to Sept 11 1945, and that I last saw him alive on Sept 10 19 45.

Immediate cause of death	Duration
Poliomyelitis	
Due to Poliomyelitis bulbar	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Sydenham Hosp Date signed 9/11/45

G32315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G32315
Registered No.

Every item of information should be carefully answered. Please write plainly, with UNFADING INK. Every item must be answered, or "unknown" if impossible or not applicable. Do not use abbreviations except where directed. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 65 E Ramsay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 65 E. Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Bauer.
3 (b) If veteran, name war
3 (c) Social Security Account No. None
4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mary Norma Collins
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/10/1883
8. AGE: Years 62 | Months 3 | Days 20 | If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Dye Maker
11. Industry or business (Retired)
FATHER 12. Name Joseph Bauer
13. Birthplace Balto Md.
MOTHER 14. Maiden Name Margaret Epp
15. Birthplace Balto Md.
16 (a) Informant Miss M Bauer
(b) Address 65 E Ramsay
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Catonsville
18 (a) Funeral director J. F. Flanagan Sons
(b) Address 1318 Light St
Huntington Williams M.D. Registrar
1945 (Date rec'd by registrar)
12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/45 19 , at 5:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1945 to Sept 9 1945, and that I last saw h alive on Sept 9 1945.

	Duration
Immediate cause of death Chronic Myocarditis	2 mos.
Due to	
Due to Anaemia	6 mos.
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: None	

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. M. Mitchell
Address 1279 Millcam St Date signed 9/10/45 M. D.

X

G32316 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G32316

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2817 Overland Ave. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME George Milton Beane

If U. S. Veteran specify WAR.

(a) Residence: No. 2817 Overland Ave. Ward 27-2

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: Jane Hall Beane

6. DATE OF BIRTH (month, day, year): January 8, 1882

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	8	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Dealer in Rough Coal

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Saw Mill

10. Date deceased last worked at this occupation (month and year): July

11. Total time (years) spent in this occupation: 43 yrs

12. BIRTHPLACE (city or town) (State or country): Miskinon, Md

FATHER

13. NAME: James Thomas Beane

14. BIRTHPLACE (city or town) (State or country): Miskinon, Md

MOTHER

15. MAIDEN NAME: Annie Sampson

16. BIRTHPLACE (city or town) (State or country): Miskinon Md

17. INFORMANT: Annie Ive Bell (Address) 2817 Overland Ave

18. BURIAL, CREMATION, OR REMOVAL: Place Ramswood, Date 9/12/45, 19...

19. UNDERTAKER: Henry W. Sauter & Son (Address) Mortuarians & Embalmers

20. FILED SEP 12 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): September 11, 1945

22. I HEREBY CERTIFY, That I attended deceased from September 1945 to September 11, 1945

I last saw him alive on September 11 1945 Death is said to have occurred on the date stated above, at 1055 A.M.

The principal cause of death and related causes of importance are as follows:

	Date of onset
Cerebral Hemmhage.	8 Sep.
Cardiac Hypertensive Disease	1940
Other contributory causes of importance:	

Was an operation performed? No Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Physical exam't Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Albert E. Greenberg M. D.

(Address) 2025 E. North Ave.

OCCUPATION is very important. See instructions on back of certificate.

VS 3

G32317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G32317

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 S. East ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Gigous, Mrs. Anna~~ ANNA GIGOUS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Howard Gigous

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Feb 3, 1895

8. AGE: Years 50 | Months 9 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. Balto. Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert Fannekoll
13. Birthplace Germany.

MOTHER
14. Maiden Name SOFIE HORN
15. Birthplace Germany.

16 (a) Informant Howard Gigous - husband
(b) Address 204 S. East Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEMETERY
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS?INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 12 1945 (Date rec'd by Local Reg.) Huntington Williams, M.D. (Signature of Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1945 to 9/9 1945 and that I last saw h[illegible] alive on 9/9 1945.

Immediate cause of death Shock — Duration: 1 week

Due to Bronchopneumonia + Diabetic condition

Due to Arteriosclerosis

Other Conditions Diabetes mellitus, status epilepticus, osteomyelitis skull
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Osteomyelitis skull Bronchopneumonia & Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest M. Lairmore M. D.
Address Church Home & Hosp Ct Date signed 9/10/45

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly, with UNFADING INK.

G32318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G32318

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 E. 33rd. St.
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E 33rd. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES CHRISTOPHER JENKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Margaret Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1860

8. AGE: Years	Months	Days	If less than one day
85	1	10	hr. min.

9. Birthplace Relay, Md
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name David Jenkins
13. Birthplace Relay, Md.

MOTHER
14. Maiden Name Caroline Turner
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Milton Schreck
(b) Address 1609 E 33rd. Street

17 (a) Burial (b) Date thereof 9- 13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

SEP 12 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH Sept. 10, 1945, at 1.30 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1941 to Sept. 1945 and that I last saw him alive on 9/7/1945.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens M. D.
Address 3400 Eastern Ave Date signed 9/10/45

VS 150

X

J. von Drake

632319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 632319

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 Remington Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Remington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Nannie E. Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female

5 Color of race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward R. Thomas, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10-1876

8. AGE: Years 69 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Clarke Co. Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name — Stickels
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Virginia

16 (a) Informant Edward R. Thomas Sr.
(b) Address 3120 Remington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

SEP 12 1945 (Date received) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11- 1945 at 12 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Sept 11 1945 and that I last saw h[illegible] alive on Sept 10 1945.

Immediate cause of death: Cerebral Hemorrhage (2nd) — Duration 2 1/2 yrs.
Due to Hypertension
Due to Senile Degenerative disease.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Dr.
Address [illegible] 3687 - Date signed 9/11/45

VS 150

G323320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G323320

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Homestead Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Homestead Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Kidd

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-12-5310

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Loretto Kidd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1869

8. AGE: Years	Months	Days	If less than one day
76	2	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Black Mfg. Co.

FATHER
12. Name George Kidd
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Serena Crane
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Loretto Kidd
(b) Address 700 Homestead St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept. 13-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Quigley Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 12 1945 (Date received by Registrar) (b) Burington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 7 45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1945 to Sept. 9 1945, and that I last saw him alive on Sept. 9 1945.

Immediate cause of death Cirrhosis liver. — Duration 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Stuckelberg M. D.
Address 632 Tunnel a Date signed Sept 10/45

X

G323521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G323521

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Allendale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR WRIGHT LOCKARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	214-18-7689

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah S. Lockard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	13	hr. min.

9. Birthplace Pikesville, Md.
(Town, county, and state)
10. Usual Occupation Stocks & Bonds Salesman
11. Industry or business Self

FATHER
12. Name John E. Lockard
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Wright
15. Birthplace Md.

16 (a) Informant Mrs. Catherine Ingalls
(b) Address 2405 Allendale Rd. 16

17 (a) Burial (b) Date thereof 9/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stone Chapel Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1945, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 11 1945 and that I last saw him alive on Sept 10 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
and paralysis	
Due to advanced Arterio Sclerosis	?
Due to Hypertension	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Wilbert M. D.
Address 2220 Garrison Blvd. Date signed Sept. 12/45

VS 150

S322322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. S322322

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 312 N. Exeter St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Salto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 312 N. Exeter St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Pearl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1909

8. AGE: Years	Months	Days	If less than one day
35	8	29	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Special Police

11. Industry or business

FATHER 12. Name Thomas Miller

13. Birthplace ?

MOTHER 14. Maiden Name Estelle Holmes

15. Birthplace Va

16. (a) Informant Estelle Trusty

(b) Address 312 N Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A. A. County, Md.

18 (a) Funeral director Joseph E. Lockard

(b) Address 1354 N. Central Ave

19 (a) SEP 12 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1945, to Sept 7 1945, and that I last saw him alive on Sept 7 1945.

Immediate cause of death	Duration
Acute respiratory Failure	7
Due to Chronic pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A.C. Burwell M. D.

Address 121 Augusta Date signed 9-9-45

VS 190

6323323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6323323

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2433 Mceldery St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2433 Mceldery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Eckhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine C. Eckhoff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1866

8. AGE: Years 78 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eckhoff
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. Catherine C. Eckhoff
(b) Address 2433 Mceldery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director John L. Miller
(b) Address 2634 Jefferson St.

19 SEP 12 1945 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 59 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1945, to Sept 10 1945, and that I last saw him alive on Sept 9 1945.

Immediate cause of death: Coronary occlusion — Duration 1 hr.

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Dovak M. D.
Address 101 W. Read St Date signed 9-11-45

VS 100

X

Every item of information should be carefully supplied. WRITE WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G322324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G322324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Huntington ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 1 2 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Huntington ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Marian G. Benson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. E. Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 - 1891

8. AGE: Years 54 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Peter a. Wallick
13. Birthplace Pa

MOTHER
14. Maiden Name Mary a. Leightner
15. Birthplace Md

16 (a) Informant Mrs. Wm. E. Benson
(b) Address 2613 Huntington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Geo. E. Boyer Jr
(b) Address 1512 Bolton St

19 (Signature of registrar) SEP 12 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945, to Sept 8 1945, and that I last saw her alive on Sept. 8 1945.

Immediate cause of death: Cardiac failure — Duration: —

Due to: Intestinal Hemmorage — Duration: —

Due to: — Duration: —

Other Conditions — Duration: —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Walter G. Crapp M. D.
Address 537 Wildwood Pkwy Date signed 9-11-45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G323325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 109a

G323325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Clifton Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Glenville H. Castle

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	16	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Supervisor B & O RR
11. Industry or business

FATHER
12. Name Harry Castle
13. Birthplace W. Va

MOTHER
14. Maiden Name Ella McElhoes
15. Birthplace W. Va

16 (a) Informant Mrs Ellen Castle
(b) Address 3512 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (month) (day) (year)
(c) Cemetery or crematory
Location Keyser W. Va

18 (a) Funeral director Leo F Berry Jr
(b) Address 167 E Hollins St

19 (a) SEP 12 1945 (Date rec'd by registrar) (b) Interring for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 12 1945 and that I last saw h[illegible] alive on Sept 11 1945

Immediate cause of death	Duration
Respiratory Collapse	
Due to Typical Virus pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips
Address Md. Gen. Hosp. Date signed 9/12/45 M. D.

VS 2

6323326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 6323326 131a

Correct age is especially important. Physicians: please write the dates of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 Longwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Longwood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary J. Woolley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	widow

6 (b) Name of husband or wife Daniel F. Woolley
6 (c) If alive, give age years
Deceased

7. Birth date of deceased (mo., day, yr.) 12/29/1866

8. AGE: Years	Months	Days	If less than one day
78	8	12	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Nyloe
13. Birthplace Ireland

MOTHER
14. Maiden Name Sallie Dignan
15. Birthplace Ireland

16 (a) Informant Mrs Louise Woolley
(b) Address 1205 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Catherine
Location Baltimore

18 (a) Funeral director H. C. Brauning Son
(b) Address 2924 Edmondson Ave

SEP 12 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10th 1945 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1945 to Sept. 10 1945, and that I last saw her alive on 10 Sept. 1945.

Immediate cause of death	Duration
Paralysis	5 month
Due to Cerebral hemorrhage	
Due to Chronic Nephritis and hypertension	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Bound M. D.
Address 2 West Read St. Date signed Sept. 12

G32527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1002

G32527

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Notre Dame Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 NOTRE DAME LANE
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Dorothy Rebecca White
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 214-14-8115

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) AUG. 24 1904

8. AGE: Years	Months	Days	If less than one day
41	—	17	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation NURSE
11. Industry or business

FATHER
12. Name CHARLES OWEN WHITE
13. Birthplace BALTIMORE MARYLAND

MOTHER
14. Maiden Name MARGARET HOFF
15. Birthplace BALTIMORE Co.

16 (a) Informant MRS. W.E. STANSBURY
(b) Address 2201 ELLAMONT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 13-45 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location EDMONDSON AVENUE.

18 (a) Funeral director CHESTER WEBER
(b) Address 2503 EDMONDSON AVE.

19 SEP 12 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945, at 12 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1945 to Sept 10 1945.
and that I last saw h[illegible] alive on Sept 9 1945.

Immediate cause of death [illegible]

	Duration
Due to [illegible] - Left leg	Months
Due to D.T.S. Acute 8/27/45 - Left Lower Leg Amputation - Dr. Bonzer	8/21 to 9/10/45
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 6128 York Rd. Date signed 9/12/45

XHEGHINIMN

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32328

BALTIMORE CITY HEALTH DEPARTMENT

BHP #55823

CERTIFICATE OF DEATH

133a

Registered No. G32328

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 3 & 19

(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1810 N. Bond St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte, Jewell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1868

8. AGE: Years	Months	Days	If less than one day
77	?	?	hr. min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ? ?

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Baltimore City Hpsitals Records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-45 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Baltimore, Md.

18 (a) Funeral director Harry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

SEP 12 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 21, 1940, to Sept. 10, 1945, and that I last saw her alive on Sept. 10, 1945.

Immediate cause of death
Uremia — Duration 4 days

Due to pyelonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret Davis M. D.

Address 4940 Eastern Ave. Date signed 9-10-45

VS 150

X

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G322329

HEALTH DEPARTMENT—CITY OF BALTIMORE

G322329

CERTIFICATE OF DEATH

1. PLACE OF DEATH Kernan Hospital 14

Registered No.

CITY OF BALTIMORE: (No. Forest Park Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Robert Spicer (SPICER)

If U. S. Veteran specify WAR

(a) Residence: No. Highland - Howard Co. Md. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 11-4-41

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
3	10	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Olney Md.

FATHER

13. NAME Garnet Spicer

14. BIRTHPLACE (city or town) (State or country) N. C.

MOTHER

15. MAIDEN NAME Catherine Brooks

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT Garnet Spicer
(Address) Clarksville, Md

18. BURIAL, CREMATION, OR REMOVAL
Place Guilfoyle Chapel Date 9-13 19 45
Clarksville, Md.

19. UNDERTAKER J. C. Higginbotham
(Address) Ellicott City, Md

20. FILED SEP 12 1945 Registrar for Baltimore City

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/10, 1945

22. I HEREBY CERTIFY, That I attended deceased from 3/23, 1945, to 9/10, 1945

I last saw him alive on 9/10, 1945. Death is said to have occurred on the date stated above, at 9:00 a.m./p.m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
1 Tuberculous meningitis	9/3/45
2. Tuberculosis hips-bilateral	11/44
Other contributory causes of importance:	

Was an operation performed? NO Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
NO If so, specify

(Signed) George D. Appleby M.D.
(Address) Kernan Hospital

OCCUPATION is very important. See instructions on back of certificate. Exact statement of

VS 2

G32330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32330
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Arizona Ave
(c) Hospital or institution: 26th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4206 Arizona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia E Mc Ginn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Sm

6 (b) Name of husband or wife Robt M. McGinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15. 1873

8. AGE: Years	Months	Days	If less than one day
72	3	4d	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation (

11. Industry or business At Home

FATHER 12. Name Henry Haden
13. Birthplace Va

MOTHER 14. Maiden Name Hester W Pitt
15. Birthplace Md

16 (a) Informant Henry P. McGinn
(b) Address 4206 Arizona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St

19 DEC 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1945 at 4:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10- 1944 to 9-11- 1945 and that I last saw her alive on 9-11- 1945

	Duration
Immediate cause of death Chronic myocardial degeneration	1 yrs
Due to Generalised arteriosclerosis	?
Due to	
Other Conditions Left hemiplegia	14 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang
Address 2117 Belair Rd Date signed 9-11-45 M. D.

VS 150

G32331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32331

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1129 Riverside Ave.
(c) Hospital or institution: 24-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Meyd

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Frances Meyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1860

8. AGE: Years	Months	Days	If less than one day
85	7	10	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Conrad Meyd
13. Birthplace Germany

MOTHER
14. Maiden Name Magdaline Kaufmann
15. Birthplace Germany

16 (a) Informant Miss Regina Meyd
(b) Address 1129 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elizabeth Hartle Func.
(b) Address 115 E. West St.

19 (a) SEP 12 1945 (Date rec'd by registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 4.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 10 1945 and that I last saw h[illegible] alive on Sept 10 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis + Degeneration	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Schemmel
Address 1334 S. Charles St. Date signed 9/11/45

VS 150

G32332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82B

Registered No. 132332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

Before moved to county — 20 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Mt. Airy

(If outside city or town limits, write RURAL and give town)

(d) Street No. RFD

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Walter Lee Stem

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	

6 (b) Name of husband or wife: Florence S Stem

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Sept 26 1880

8. AGE: Years	Months	Days	If less than one day
64	11	15	hr. min.

9. Birthplace Union Bridge Md.

(Town, county, and state)

10. Usual Occupation Boilermaker

11. Industry or business

FATHER

12. Name Harry S Stem

13. Birthplace Libertytown, Md.

MOTHER

14. Maiden Name Nellie S Stevens

15. Birthplace Frederick, Md.

16 (a) Informant Harry S Stem

(b) Address 1602 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. W Tyler

(b) Address 1101 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registrar

SEP 13 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11/45 19 , at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1945 to 9/11 1945, and that I last saw h[illegible] alive on 9/11 1945

Immediate cause of death Acquisition Pneumonia Diffuse

Due to Paralysis 1 muscles of deglutition & respiration

Due to Thrombosis of Posterior Inferior Cerebella Artery

Other Conditions Due to Arteriosclerosis

Pregnancy: (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days
8 days
8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard T. Kurland M.D.

Address University Hospital Date signed 9/12/45

GPO 180

G332333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1 b

Registered No. G332333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Preston & Linwood
(c) Hospital or institution: Preston Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Deimel
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-07-9160

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Frances A. Deimel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1864

8. AGE: Years 81 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Box Mfgr.

11. Industry or business

FATHER
12. Name Frank A. Deimel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Deive
15. Birthplace Germany

16 (a) Informant Mrs Francesca. Deimel
(b) Address 218 E Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Wendell E. Humphreys
(b) Address 667 Harford Rd

19 (a) SEP 13 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1945, at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920, to Sept 11 1945, and that I last saw h[illegible] alive on Sept 10 1945.

	Duration
Immediate cause of death: Acute cardiac dilatation	1 2 hrs
Due to Chr Nephritis	6 Yrs (?)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Hayward
Address 115 E Eager St Date signed 9/14/45 M. D.

Huntington Williams, M.D.

X

CORRECTIONS, IF ANY, MADE ONLY BY USE OF INDELIBLE INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 12 - 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City. (If outside city or town limits, write RURAL, and give town)
(d) Street No. 203 Paddington Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward V. Milholland, M.D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose Marie Barry

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1873

8. AGE: Years 71 | Months 9 | Days 27 24 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Medical Doctor.

11. Industry or business

FATHER
12. Name Edward F. Milholland
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Collins
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Rose Marie B. Milholland
(b) Address 203 Paddington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert Street

19 (a) SEP 13 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1945 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Sept 11 1945, and that I last saw h[illegible] alive on Sept 11 1945.

Immediate cause of death
(a) Acute genito - urinary infection
(b) Chronic cardio - vascular disease
(c) Prolonged hypostatic pneumonia
Due to (a) (b) (c) respectively

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Dorcas Clark, M.D.
Address University Hospital Date signed 9-13-45

6322335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55e

6322335 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 W. University Pkwy.
(c) Hospital or institution: 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 29 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Brian F. Murphy, M. D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -------

6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) ------- 1916

8. AGE: Years 29 | Months --- | Days --- | If less than one day -- hr. -- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Doctor of Medicine

11. Industry or business -------

FATHER
12. Name John L. V. Murphy
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Edith H. Meyer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Edith H. Murphy
(b) Address 104 W. University Parkway

17 (a) Burial (b) Date thereof 9/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meears and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b) [illegible]
(Date received by registrar) Huntington Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 12:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1945 to Sept. 10 1945 and that I last saw [illegible] alive on Sept. 10 1945.

Duration

Acute Cerebral Failure

Due to Carcinoma of Uterus - 2 yrs

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature Brian F. Murphy
Address [illegible] Date signed 9/12/45

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46h

G32336 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park and 31st Street
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo10da
(e) Length of stay in Baltimore (yrs., mos., or days) 1mo 10 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Stoneham (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Westcott Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DONALD ROSS SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Marjorie Edgecomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/1895

8. AGE: Years	Months	Days	If less than one day
49	11	2	hr. min.

9. Birthplace Albany, New York (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret MacFarland
15. Birthplace Scotland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 15 45 (month) (day) (year)
(c) Cemetery or crematory
Location Stoneham, Mass

18 (a) Funeral director A. Lee Oder
(b) Address 644 York Road.

19 (a) SEP 13 1945 (Date received by registrar) Registrar for Wilt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1945, at 11:10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1945, to Sept. 12, 1945, and that I last saw him alive on Sept. 12, 1945.

Immediate cause of death	Duration
Adenocarcinoma of gall bladder;	Unk.
Carcinomasosis of peritoneum	Unk.
Due to and pleura	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/9/45
Major findings of operation: Expl. Lap
of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Wilson J. L. Wilson-Sr. Surg. USPHS M. D.
Address US Marine Hospital Date signed

VS 150

G32337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32337 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 N. Bouldin Street
(c) Hospital or institution: 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Bouldin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HEDERSON TRUEHEART

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-12-6637
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha Louise Trueheart
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) June 12, 1871
8. AGE: Years 74 | Months 2 | Days 4 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Gayety Theatre

FATHER
12. Name William Trueheart
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy White
15. Birthplace Virginia

16 (a) Informant Mrs. Bertha L. Trueheart
(b) Address 415 N. Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 13-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem. Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
(Date rec'd by registrar) SEP 13 1945 Registrar Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 18 1945, to Sept 6 1945; that I last saw him alive on Sept 6 1945.

Immediate cause of death	Duration
Coronary Thrombosis	10 days
Due to Cardio Vascular disease	2.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Sanders M. D.
Address 100 N. Melton Ave. Date signed 9/12/45

G32338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

V. G32338 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dukeland
(c) Hospital or institution: West Balt. General Hosp. 9-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days) 3d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 2777 Tivoly ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Marie La Rocca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1945

8. AGE: Years | Months | Days 3 | If less than one day ... hr. ... min.

9. Birthplace W. B. H. H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stephen La Rocca

13. Birthplace Glen Campbell Pa

MOTHER 14. Maiden Name Mary Pagliano

15. Birthplace Balt Md

16 (a) Informant Stephen La Rocca (Father)

(b) Address 2777 Tivoly ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd

18 (a) Funeral director Frank Adler Noel

(b) Address 52 N. Marley st.

19 (a) SEP 13 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/11 1945, and that I last saw her alive on 9/11 1945.

Immediate cause of death Intracranial Hemorrhage.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lilienfeld, M.D.
Address West Balt. Gen. Hosp. Date signed 9/11/45

VS 180

X

632339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 632339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5629 Govane Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6100 Hazelwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine E. Ballweg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Henry J. Ballweg (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21st 1876

8. AGE: Years	Months	Days	If less than one day
69	1	20	hr. min.

9. Birthplace Syracuse N.Y. (Town, county and state)
10. Usual Occupation Housewife - Sales lady
11. Industry or business R.J. May Co.

FATHER
12. Name Frank Sayder
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henry J. Ballweg
(b) Address 6100 Hazelwood Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)
(c) Cemetery or crematory Assumption
Location Syracuse N.Y.

18 (a) Funeral director William Cook Bros.
(b) Address 1217 St. Paul St.

19 (a) SEP 13 1945 (Date received by Registrar) (b) Huntington Hillman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11th 1945, at 10 15 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945, to Sept 11 1945, and that I last saw her alive on Sept 10 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	8 days
Due to Arteriosclerosis	10 years
Due to Complications	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 4810 Belair Rd Date signed Sept 11/45

VS 150

G32340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G32340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 St. Paul St
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A. De Hoff

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-22-9998

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Ethel De Hoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28 1887

8. AGE: Years	Months	Days	If less than one day
58	5	13	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Hoffman & Roberts

FATHER
12. Name Louis A. De Hoff
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Kolbe
15. Birthplace Md

16 (a) Informant Mrs. D. Steibel
(b) Address 1618 St. Paul st.

17 (a) Burial (b) Date thereof 9/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Chestnut Ridge
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) SEP 13 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945 at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. L. Pulaski M.D.
Medical Examiner.
Date signed 9/14/45

Huntington Pharmacy, Md.

X X

The space is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

G32341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G32341 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 St Paul St
(c) Hospital or institution: 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D&A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Ivey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Anna Belle Ivey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Lumberton N.C.
(Town, county, and state)

10. Usual Occupation Messenger

11. Industry or business Railway Express

FATHER
12. Name James R. Ivey
13. Birthplace Florida

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Wilton R. Ivey (Son)
(b) Address 1614 St. Paul st (Ver 8048J)

17 (a) Removal (b) Date thereof 9/13/45
(burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Maxton
Location N.C.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945, at M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Fulcomiti M.D.
Medical Examiner.
Date signed 9/12/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G32342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G32342 Registered No.

PRINCIPAL WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2105 Huntington ave
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Huntington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry William Lohmeyer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Charlotte B. Lohmeyer
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 16 1871

8. AGE: Years	Months	Days	If less than one day
74	2	26	— hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter

FATHER
12. Name William Lohmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Jacob Lohmeyer - Son
(b) Address Pikesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13-45 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Pleasant Hill. Balto. Co. Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

19 (a) SEP 13 1945 (Date rec'd by Registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945 at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/11 1945
and that I last saw him alive on 9/10/11 1945.

Immediate cause of death Cerebral Haemorrhage — Duration 8-1 day
Due to Arteriosclerosis — Many yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh Leavell M.D.
Address 302 Bromley Date signed 9/12/45

VS 150

G32343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 50

Registered No. G32343

PRINCE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Braddish Ave.
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Braddish Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LILLIE T. SUTTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Walter P. Sutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	2	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Tolle
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Eberlein
15. Birthplace ?

16 (a) Informant Miss Dorothy E. Sutton
(b) Address 1500 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 12 1945 (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 10, 1945, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Sept 10 1945 and that I last saw h[er] alive on Sept 10 1945.

Immediate cause of death	Duration
Carcinoma of lungs	1 Yr
Due to Carcinoma of breast	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer C. Todd M.D.
Address 735 N. Fulton Ave. Date signed 9/12/45

VS 150

Huntington Williams, M.R

K

JO #95827 G32344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 f

Registered No. G32344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 Thames St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William McGrath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	10	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas McGrath
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director Edward J. Gorman & Son
(b) Address 1218 Light St.

19 (a) SEP 12 1945 (Registered in register's office) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1945, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1945, to Sept. 2, 1945, and that I last saw him alive on Sept. 2, 1945.

Immediate cause of death	Duration
Pulmonary tuberculosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Dawson M. D.
Address 4940 Eastern Ave. Date signed 9-11-45

VS 150

DUPLICATE MADE BY CARBON, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32345 Registered No.

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 5-2 Johns Hopkins Hosp.
(d) Length of stay in hospital or inst: (yrs., mos., or days) d : 0 : a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 596 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shadrach Scott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife Isabella Scott
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 6-6-80

8. AGE: Years	Months	Days	If less than one day
65	3	4	hr. min.

9. Birthplace Lynchburg - Va. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Wilcox Bldg. 6 E Aisquith St.

FATHER
12. Name ?
13. Birthplace Va

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant David V. Scott
(b) Address 1530 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Halethorp, Md.

18 (a) Funeral director Charles K. Law
(b) Address 802 Madison Ave.

19 (a) (Date rec'd by Registrar) SEP 13 1945 (b) Registered Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral embolism cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 9-11-45

G32346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 143
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 N. Brunt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Erskine Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1945

8. AGE: Years	Months	Days	If less than one day
[redacted]	1		hr. min.

9. Birthplace BALTO. Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ODELL BAILEY
13. Birthplace LAURENCE S. C.

MOTHER
14. Maiden Name Louise McClintock
15. Birthplace Laurence S. C.

16 (a) Informant Birth Certificate
(b) Address # 2-354204

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 13 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1945, at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Prematurity

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malone M.D. Medical Examiner.
Date signed Aug. 30, 1945

VS 151

2930

X

Type, typewrite, or rubber stamp; please write the causes of death clearly and legibly.

632347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

632347 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14-3
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Brent St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Earl Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1945

8. AGE: Years	Months	Days	If less than one day
	1		hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Odell Bailey
13. Birthplace Laurence, S.C.

MOTHER
14. Maiden Name Louise McClintock
15. Birthplace Laurence S.C.

16 (a) Informant Birth Certificate
(b) Address #35425

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945, at 4:5 A.M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Prematurity

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mercer M.D. Medical Examiner.
Date signed 8/31/45

VS 151

2949

632348 ✓ 632348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 921

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 Dallas Ct
(c) Hospital or institution: 6-S

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore, md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Dallas Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Mackey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Mackey
13. Birthplace Va, r

MOTHER
14. Maiden Name Rozella Howard
15. Birthplace Va

16 (a) Informant Rebecca Mackey
(b) Address 209 Dallas Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) SEP 13 1945 Registrar
(Date received by State Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1945, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 11 1945, and that I last saw h.e alive on Sept 10 1945.

Immediate cause of death: Mitral Insufficiency — Duration
Due to Cardiac Asthma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Kirkus M. D.
Address 1612 E. Monument Date signed 9-11-45

Burington Williams, M.D.

VS 180

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G32349 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Kolb Ave
(c) Hospital or institution: 26-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Kolb Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Harberts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gerhard Harberts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/10/65

8. AGE: Years 80 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Katherine Price
(b) Address 5 Madaline Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by registrar) SEP 13 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1945 at 3-05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1945 to Sept 12 1945 and that I last saw her alive on Sept 12 1945.

Immediate cause of death: Chronic myocardial disease — Duration 3 yrs

Due to:

Due to:

Other Conditions: Arteriosclerosis — 3 yrs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Lee Thiehoff

Address 4116 Northern Pkwy Date signed 10/10/45

X

G32350

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G32350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phyllis R. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25, 1917

8. AGE: Years 27 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER
12. Name Dr. Jacob Fisher
13. Birthplace Patterson, N. J.

MOTHER
14. Maiden Name Ethel Stoddard
15. Birthplace Baltimore, Md.

16 (a) Informant Dr. Jacob Fisher
(b) Address 2605 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem. Park
Location Taylor Ave, Balto. Md.

18 (a) Funeral director Howard W. Blight Jr.
(b) Address 4914 Belair Road

19 (a) SEP 13 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 19 45 at 11:25 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Barbiturate Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 9, 1945 at 10 P M.
(b) Where did injury occur? 3215 St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Apartment While at work? No
(d) Means of injury Swallowed Sodium Amytal Capsule.

23. Signature Robert Lee Sutton M.D. Medical Examiner.
Date signed Sept. 13, 1945.

Huntington Hollins, MD

VS 151

G32351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G32351
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St.
(c) Hospital or institution: Bon Secours Hosp. 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1653 McKean Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sharon Ann Hansell

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: F

5. Color or race: W

6 (a) Single, ~~married, widowed~~, or divorced.

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1945

8. AGE: Years | Months | Days: 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name James Hansell
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden Name Aleda Schultz
15. Birthplace Cumberland, Md.

16 (a) Informant Mrs. Aleda Hansell
(b) Address 1653 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/45 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cemetery
Location Cumberland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) (b) Registrar

VS 150 SEP 13 1945 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/1945 at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12/1945 to 9/12/1945 and that I last saw h[illegible] alive on 9/12/1945

Immediate cause of death	Duration
Bronchial Pneumonia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Chas Norton Jr. M. D.
Address Bon Secours Hosp. Date signed 9/12/45

G33352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1311

G33352

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 - Orchard St.
(c) Hospital or institution: 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Orchard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Estelle Ausby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife: William Ausby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1901

8. AGE: Years	Months	Days	If less than one day
43 44	11	11	hr. min.

9. Birthplace: Charlottsville Va. (Town, county, and state)
10. Usual Occupation: Domestic
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Charlotte Lewis
15. Birthplace: Va

16 (a) Informant: William Ausby
(b) Address: 530 Orchard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Md.

18 (a) Funeral director: Nicholas Halstead
(b) Address: 918 Druid Hill Ave.

SEP 13 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 - 1945 to Sept-12-1945, and that I last saw her alive on Sept-12-1945

Immediate cause of death: Myo-cardial insufficiency — Duration: indefinite

Due to: Aortic & Mitral insufficiency —

Due to: Chronic-Nephritis

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herman Seidel M.D.
Address: 2402 Eutaw Date signed 9/13/45

VS 150

X

G32353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32353 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 Cleveland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Womack

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-1206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
C	M	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	6	hr. min.

9. Birthplace Halifax Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Bell Womack
13. Birthplace Halifax, Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mollie Womack
(b) Address 1338 Cleveland St

17 (a) Burial (b) Date thereof 9-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Alburn Cem
Location Md

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) SEP 18 1945 (b) Huntington Williams
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1945, at 4:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Fahrenkamp M.D.
Medical Examiner
Date signed 9/11/45

632354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 b

632354 Registered No.

Please write clearly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 ORELEANS ST.
(c) Hospital or institution: 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 ORELEANS ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN J. EMKEY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARTHA EMKEY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 27 1864

8. AGE: Years 81 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation BRICKLAYER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant MARTHA ETZEL
(b) Address 625 MARYLAND AVE. ESSEX

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 15/45 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly and Zeilenbach
(b) Address 403 S. WOLFE ST.

19 (a) SEP 13 1945 (Date rec'd by registrar) (b) Huntington Williams Mortician

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 12 1945 at 9/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 19 45 to 9/12 19 45, and that I last saw h[illegible] alive on 9/11 19 45.

Immediate cause of death Carcinoma of the stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Strum M.D. Address 3210 Eastern Ave
Date signed 9/13/45 A. D.

X

VS 150

G32355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G32355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: Local Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dcd
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bayard Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9396

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Madene

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1923

8. AGE: Years 22 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Green Co., N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles L Moore
13. Birthplace N.C

MOTHER
14. Maiden Name Emma Hardy
15. Birthplace N C

16 (a) Informant Emma Dempsey
(b) Address 811 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 14 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director J S Brown & Son
(b) Address 108 W Montgomery St

19 (a) SEP 13 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1945 at 4 50 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-10-45 at 4 23 a. M.
(b) Where did injury occur? Ostend & Warner Sts Hoskins manufac. Co
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? No
(d) Means of injury Shooting

23. Signature [illegible] M.D. Medical Examiner.
Date signed Sept. 10 1945

VS 151

X

G32356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G32356

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 Aull St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County,
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Aull St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1875

8. AGE: Years 70 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name
13. Birthplace unknown

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Unknown

16 (a) Informant Nettie Wilson
(b) Address 628 Aull St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Assn
Location Baltimore County Md

18 (a) Funeral director Mrs. Robert F. Elliott & Dgt
(b) Address 1129 N. Caroline St.

19 (a) (b)

SEP 13 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 19 45 at 7 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 10 1945 and that I last saw h. alive on Sept 10 1945

Immediate cause of death: Chronic Interstitial Nephritis — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 2029 Jones Falls Date signed Sept 12 45

VS 150

632357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

632357

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Davis Chemical Co.
(c) Hospital or institution: Curtis Bay, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 766 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas R. Seckford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pearl A. Seckford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1893

8. AGE: Years 52 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Motorman & Brakeman

11. Industry or business Davis Chemical Co

FATHER 12. Name Thomas R. Seckford

13. Birthplace Va.

MOTHER 14. Maiden Name Frances Jenkins

15. Birthplace Va.

16 (a) Informant Pearl A. Seckford

(b) Address 766 W. Lexington St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-13-45 (month) (day) (year)

(c) Cemetery or crematory

Location Riley ville, Va

18 (a) Funeral director W. W. Chambers

(b) Address Washington, D. C.

19 (a) SEP 13 1945 (Date received by registrar) Hunting for William

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12, 1945 at 3:35 p. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Rec death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5

(a) Date of injury 9-12-45 at 3:30 p. M.

(b) Where did injury occur? Davis Chem. Co., Curtis Bay, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes

(d) Means of injury Crushed between car and platform

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Sept. 12 1945

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any information should be carefully supplied.

G32558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 64

Registered No. G32558

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kayser - Dukeland 15-4
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 17
(If outside city or town, limits, write RURAL, and give town)
(d) Street No. 2117 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Daniel Lee Bright

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2. 1945

8. AGE: Years — Months 8 Days 10 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER
12. Name Arlie Bright
13. Birthplace Farmington, Del. U.S.

MOTHER
14. Maiden Name Agnes Roe
15. Birthplace Harrington, Del. U.S.

16 (a) Informant Arlie Bright
(b) Address 2117 Clifton Ave, Balto. Md.

17 (a) Burial (b) Date thereof Sept. 14 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holly Wood Cemetery
Location Harrington, Del.

18 (a) Funeral director Wm. R. H. Boyer
(b) Address Harrington, Del.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945 at 10 ½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 12 1945 and that I last saw h[illegible] alive on Sept 12 1945.

Immediate cause of death Respiratory failure — Duration

Due to Coma — Duration

Due to Acute fulminating infection, etiology unknown — Duration

Other Conditions (over) — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hypostatic Pneumonia - Patulous

PHYSICIAN [illegible] underline the [illegible] to which [illegible] should be [illegible] statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hospital Date signed 9-12-45

VS 150 SEP 13 1945

Approved: Joseph C. Sladen M.D. X

G32359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G32359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4320 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-018-896A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret Eyler Jones
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 11/13/77

8. AGE: Years	Months	Days	If less than one day
68	9	28	hr. min.

9. Birthplace Brookville, Montgomery Co. Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Wm. Hanks Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen Parsley
15. Birthplace Md.

16 (a) Informant Mrs. Margaret E. Jones
(b) Address 4320 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)
(c) Cemetery or crematory Salem,
Location Brookville, Montgomery Co. Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) SEP 13 1945 (Date received by registrar) (b) Huntingtown, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1945 at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1945 to Sept. 11 1945, and that I last saw him alive on Sept. 11 1945

Immediate cause of death Circulatory Failure — Duration 1 day

Due to Arteriosclerotic Cardio-Vascular Disease. —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alvin H. Hemmeter M. D.
Address University Hospital Date signed 9/1/45

X Hosp. Superintendent

G32360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G32360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 N. Castle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Sadowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-4382

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Josephine Sadowski | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1886

8. AGE: Years 59 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Retired

FATHER 12. Name —

13. Birthplace Poland

MOTHER 14. Maiden Name —

15. Birthplace Poland

16 (a) Informant Stanley Sadowske

(b) Address 1916 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13th 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Cook

(b) Address 1701-03 N. Patterson Park

SEP 13 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

Dr. Weiss 1927 E. North Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1945, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945, to 9-10 1945

and that I last saw h[illegible] alive on 9-10 1945

Immediate cause of death Bronchio-Pneumonia

Due to Carcinoma of Sigmoid Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weiss 2d M. D.

Address 1927 E. North Ave Date signed 9/10/45

G32361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G32361

PRESS WHITE PLATE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution: CONVALESCENT HOME.
(d) Length of stay in hospital or inst. (yrs., mos., or days) #.3.YR
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 PATTERSON PARK AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE FOSTER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wright
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs D. Peck
(b) Address 1709 N Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14th 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo Zelenak
(b) Address 1701-03 N. Patterson Park ave

SEP 13 1945 (Date rec'd by registrar) (b) Huntington Willis (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 11 1945 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 11 1945 to SEPT 11 1945 and that I last saw her alive on SEPT 10 1945.

Immediate cause of death CHRONIC ARTHRITIS DEFORMANS — Duration 1940

Due to CHRONIC MYOCARDITIS — 1940

Due to ARTERIOR SCLEROSIS — 1940.

Other Conditions

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas T. Lantice M. D.
Address 3013 ST PAUL STREET SEPTEMBER 11.4

G322362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G322362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 524 S. Kenwood Ave
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Zeseher

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-12-9604

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Zeseher

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 2-1869

8. AGE: Years	Months	Days	If less than one day
76	6	6	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Canton Copper Works

FATHER
12. Name George J. Zeseher
13. Birthplace Pa.

MOTHER
14. Maiden Name Christina Weyrauch
15. Birthplace Pa.

16 (a) Informant Ida Zeseher
(b) Address 524 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (month) (day) (year)
(c) Cemetery or crematory Morelawn Memorial Park
Location Dundalk Ave

18 (a) Funeral director Wm. C. Miller & Son
(b) Address 2435 E. Oliver St

19 (a) Date received by registrar SEP 13 1945 (b) Interring or Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1945 at 7:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to To Sept 12 1945 and that I last saw h alive on Sept 12 1945

Immediate cause of death Cerebral apoplexy — Duration

Due to Arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Zeller M.D.
Address 2739 Eastern Ave Date signed 9/13/45

EUGENE ZELLER

VS 180

6323363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6323363

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 E. Fayette St D.A.
(c) Hospital or institution: 26-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Rethschulte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 - 1906

8. AGE: Years	Months	Days	If less than one day
39	4	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Rethschulte
13. Birthplace Germany

MOTHER
14. Maiden Name Frieda Schneider
15. Birthplace Germany

16 (a) Informant Julia E. Buettner
(b) Address 3409 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director John C. Miller Inc
(b) Address 2425 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1945, at 10:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Schmidt M.D.
Medical Examiner.
Date signed 9/14/45

K

G322364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 10

G322364

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2029 E. Pratt
(c) Hospital or institution: Sydenham Hosp 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) days
(e) Length of stay in Baltimore (yrs., mos., or days) years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2029 E. Pratt
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jerry Davis (Jerome J. Davis) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1941

8. AGE: Years	Months	Days	If less than one day
4	9 8	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace New York

MOTHER
14. Maiden Name Myrtle Stewart
15. Birthplace Baltimore

16 (a) Informant father
(b) Address 2029 E. Pratt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 15 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Philip Fenning Sons
(b) Address 202 Orleans St

19 (a) (Date received by registrar) SEP 13 1945 (b) Huntington Avenue, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1945, at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8th 1945 to Sept 12 1945.
and that I last saw him alive on Sept 12 1945.

Immediate cause of death	Duration
Heart failure	
Due to Diphtheria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 9-13-45

X

G32365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Caldwell Ave
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 William St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Frazier

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-05-4530

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Clementine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1882

8. AGE: Years	Months	Days	If less than one day
63	2	1	hr. min.

9. Birthplace St. Leonards, Calvert, Md (Town, county, and state)
10. Usual Occupation Gas meter reader
11. Industry or business Gas & Electric Co.

FATHER
12. Name James Frazier
13. Birthplace Calvert Co.

MOTHER
14. Maiden Name Clementine Mazure
15. Birthplace Calvert Co.

16 (a) Informant Mrs. Wm. Frazier
(b) Address 1433 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Wagner Funeral Home
(b) Address 1216 N. Charles St.

19 (a) (Date received by registrar) SEP 13 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 10 1945, and that I last saw him alive on Sept 10 1945.

Immediate cause of death: Cardiac failure — Duration

Due to: Intermittent cardio vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp. Date signed 9-10-45

G32366

BALTIMORE CITY HEALTH DEPARTMENT

CWK-96002

CERTIFICATE OF DEATH 1228

Registered No. G32366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days) Life ??

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N. Spring Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Creely (Margaret J. Creely)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1885

8. AGE: Years	Months	Days	If less than one day
?? 60	2	17	######## min.

9. Birthplace Maryland Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ######## Richard F. Dee
13. Birthplace ######## Ireland

MOTHER
14. Maiden Name #### Anna McGee
15. Birthplace ## Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto; Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

SEP 13 1945 (Date rec'd by registrar) (b) Huntingdon Willi... M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 11 1945 at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1945, to Sept. 11 1945, and that I last saw her alive on Sept. 11 1945.

Immediate cause of death	Duration
Acute intestinal obstruction	2
Due to unknown — Pt. was	
Due to admit. to Acc. Rm. & died 5 min. later	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Ruth M. D.
Address Balto City Hospitals Date signed 9-11-45

VS 150

Subject to the approval of Medical Exam. Approved Robert Lee Taylor M.D. Sept 13 1945

6332367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 6332367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-2
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel W Henkell Daniel W. Henkell

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 212-01-7777

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Henkell

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 18, 1896

8. AGE: Years 49 | Months 5 | Days 25 | If less than one day: hr. min.

9. Birthplace New York State
(Town, county, and state)

10. Usual Occupation Royal Typewriter Co.

11. Industry or business Typewriter Mechanic

FATHER
12. Name John W. A. Henkell
13. Birthplace United States

MOTHER
14. Maiden Name Unknown
15. Birthplace United States

16 (a) Informant Mrs. Bessie Henkell
(b) Address 109 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 2005 W. Baltimore St.

19 (a) SEP 12 1945 (Date received by registrar) (b) Hunting for Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1945 at 2:4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 13 1945 and that I last saw him alive on Sept 13 1945.

Immediate cause of death: Coronary Occlusion — Duration: Sudden

Due to: not known in this case

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1529 W Mount Pl Date signed Sept 13 1945

Approved: Robert Lee Preston M.D. Sept 13 1945

G32368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

G32368 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Linden Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward W. Trent

3 (b) If veteran, name war

3 (c) Social Security Account No. 225-01-8479

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	12	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Pimer Carp.

11. Industry or business

FATHER 12. Name William Trent

13. Birthplace Va

MOTHER 14. Maiden Name Otillie Morris

15. Birthplace Va

16 (a) Informant Hospital Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-45 (month) (day) (year)

(c) Cemetery or crematory

Location Lynchburg Va

18 (a) Funeral director John D. Mitchell & Son.

(b) Address 1900 Eutaw Place

SEP 13 1945 (b) Huntington Williams, M.D. Registrar
Date rec'd by registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1945, at 7:37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/13 1945, and that I last saw him alive on 9/13 1945.

Immediate cause of death Bilat. lobar pneumonia

Due to Atelectasis - left lung

Due to Post operative to strangulated hernia with perforation by chicken bone

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations Perforated bowel in hernial sac
Of autopsy Confirmatory

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Traynor M. D.

Address Md. General Hosp. Date signed 9/13/45

G32369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 2

G32369
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution:
Univ. of Md. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #5
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 202-07-1787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Margaret
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 1902

8. AGE: Years	Months	Days	If less than one day
43	1 0	9 1	hr. min.

9. Birthplace Wayne Pa
(Town, county, and state)

10. Usual Occupation Servant Worker
11. Industry or business Entertaining

FATHER
12. Name Ellis Wilson
13. Birthplace Pa

MOTHER
14. Maiden Name Ella Williams
15. Birthplace Pa

16 (a) Informant Margaret J. Wilson
(b) Address Westminster, Md, R.D. #5

17 (a) Burial (b) Date thereof Sept 17/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ellsworth Cemetery
Location Westminster, Md.

18 (a) Funeral director J. E. Mayers, Jr.
(b) Address Westminster, Md.

19 (a) SEP 14 1945 (b) Huntington, West Virginia, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1945, at 2:08 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 13 1945, and that I last saw him alive on Sept 13 1945

Immediate cause of death	Duration
Aortic regurgitation	
Due to Syphilitic Cardio-vascular disease	
Due to Aortic valvulitis	
Other Conditions Congestive Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Syphilitic C.V. disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Ott, Jr. M. D.
Address Univ. of Md Hosp Date signed 9/13/45

VS 150

G322370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G322370 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2622 Springhill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2622 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Shuster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Abe Mayer
13. Birthplace Russia

MOTHER
14. Maiden Name Dvara
15. Birthplace Russia

16 (a) Informant Samuel Shuster
(b) Address 2622 Springhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)

(c) Cemetery or crematory
Location Phila. Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) (b) Registrar
(Date rec'd by Local Registrar) SEP 14 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13- 1945 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1945 to Sept 13 1945
and that I last saw her alive on Sept 12 1945

Immediate cause of death: ARTERIOSclerotic C.V. Disease — Duration: 5 years
Due to: Diabetes Mellitus — 2 years
Due to: Coronary Thrombosis — 3 weeks
Due to: Cerebral Embolism — 5 min
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex D Weinstein M. D.
Address 4603 Park Ave Date signed 9/13/45

X

632571 ✓ 632571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 271 East St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 271 East St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanora Ingerson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	none	F	W	Widowed

6 (b) Name of husband or wife Birt Ingerson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1857

8. AGE: Years	Months	Days	If less than one day hr.	min.
87	11	26		

9. Birthplace State of Maine (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name unknown Ingerson
	13. Birthplace "
MOTHER	14. Maiden Name Lassalle (?)
	15. Birthplace unknown

16 (a) Informant Clara Guido
(b) Address 271 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) 9-14-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

SEP 14 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1945 to 9-10-1945 and that I last saw h[illegible] alive on 9-10 1945.

Immediate cause of death	Duration
Exhaustion	1 day
Due to Gangrene of the	and
generalized Infection	1 month
Due to Arteriosclerosis	& Three
and heart disease	
Other Conditions Mixed Neurosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 5/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 8-15-45 at ? M
(c) Where did injury occur? 271 East St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Burned by hot water

23. Signature H. Karl Neumyer M. D.
Address 11 E Chase St Date signed 9-11-45

Thomas J. Mannix, M.D.

G322372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G322372 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1758 Homestead Street
(c) Hospital or institution:
9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1758 Homestead Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin P. Kershaw

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-12-5927 A

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elnora

6 (c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1864

8. AGE: Years 81 | Months 0 | Days 9 | If less than one day: hr. min.

9. Birthplace: England (Town, county, and state)

10. Usual Occupation: Machinist

11. Industry or business: Retired

FATHER
12. Name: Henry Kershaw
13. Birthplace: England

MOTHER
14. Maiden Name: Elizabeth (?)
15. Birthplace: England

16 (a) Informant: Mrs. Elnora Kershaw
(b) Address: 1758 Homestead Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15, 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mossland Park
Location Parkville Md

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

vs SEP 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945, to Sept 12 1945, and that I last saw h[illegible] alive on Sept 12 1945.

Immediate cause of death: Myocarditis — Duration: 3 mos

Due to: Arterial Sclerosis — 5 yrs

Due to:

Other Conditions: Paralysis of Stomach, — 1 yr

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred L. Zimmerman M. D.
Address 1818 Madison Date signed 9/14/45

4 10 005 G32373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G32373 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Sandridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1900

8. AGE: Years	Months	Days	If less than one day
45	V		hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mitchell Sandridge
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan Gills
15. Birthplace Virginia

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1945 to 9-13 1945, and that I last saw h[illegible] alive on 9-13 1945.

Immediate cause of death Bilateral Bronchopneumonia

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George G. Nance
Address Johns Hopkins Hospital Signed 9/13/45

X

G32374 112 G32374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Howard & Madison
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Whatcoat
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1919

8. AGE: Years 26 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Chesley
13. Birthplace Md.

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant James Sydnor
(b) Address 1217 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 1st 9 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/45 19 ... at 8 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dawe M.D.
Medical Examiner.
Date signed 9/13/45

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G32375 G32375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Woodington Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Boy Wareheim (Barry Earl Wareheim)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15, 1944

8. AGE: Years — Months 9 — Days 28 — If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George L. Wareheim
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Frances E. Bradley
15. Birthplace Balto. Md.

16 (a) Informant Mr George L. Wareheim
(b) Address 824 N. Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Sept 14, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address North & Ka. Ave. Balto

19 (a) SEP 14 1945 **(b)** Huntington Avenue, Md.
(Registrar's signature)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1945 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/ 1944 to 9/13 1945.
and that I last saw him alive on 9/12 1945.

Immediate cause of death Cachexia — **Duration**

Due to Hydrocephalus, Spina Bifida } Congenital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 9/13/45

G32376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G32376 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ###
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zenobia Lambie

3 (b) If veteran, name war ---
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht.	Widow

6 (b) Name of husband or wife William B. Lambie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace W

MOTHER
14. Maiden Name
15. Birthplace W

16 (a) Informant Mrs. Ada Bell Gallagher
(b) Address 3800 Woodridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 14 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1945 to Sept 11 1945, and that I last saw h[illegible] alive on Sept 11 1945

Immediate cause of death Chronic Cardiac Pancreas disease — Duration 7 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emmett Rabon
Address 1730 Oglen Ave Date signed 9/13/45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32377 / 108 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1924 Christian St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adrian Gerringer ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 45

8. AGE: Years | Months 6 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Adrian Gerringer
13. Birthplace Gibbsville, Pa.

MOTHER 14. Maiden Name Katherine Bigham
15. Birthplace Baltimore

16 (a) Informant Mrs. Katherine Bigham
(b) Address 947 S. Brunswick St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn P.O. Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 200 W. Lombard St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1945 at 6:14 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1945, to 9-11 1945, and that I last saw h[illegible] alive on 9/11 1945.

Immediate cause of death: Cardiac failure
from overwhelming
~~Duration~~ Infection

Due to Bilateral pneumonia
Med. Incl.

Other Conditions Placenta Effusion
or Lupus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jeff Russell Jr. M.D.
Address St. Agnes Hosp Date signed 9/11/45

VS SEP 14 1945 Huntington Williams M.D.

X

G34378 X G34378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Baltimore Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Baker

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife: 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20 1892

8. AGE: Years	Months	Days	If less than one day
63		19 16	hr. min.

9. Birthplace Philadelphia
(Town, county and state)
10. Usual Occupation retail business
11. Industry or business

FATHER
12. Name John Baker.
13. Birthplace Philadelphia Pa

MOTHER
14. Maiden Name Mary Kuhn
15. Birthplace Philadelphia

16 (a) Informant JOHN BAKER (BROTHER
(b) Address 118 BALTO. AVE. DUNDALK MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 17/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 SEP 14 1945 (Date received by Registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1945 at 11-03A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1945 to Sept 13 1945, and that I last saw him alive on Sept 13 1945

Immediate cause of death respiratory failure

Due to grave cachexia

Due to Cancer of breast

Other Conditions Patient had repair of hydrocele 8/29/45

(Include pregnancy within 3 months of death)

Date of operation 9/5/45 Epithelioma

Major findings of operation: Generalized Carcinoma

of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Phyllis R. Ingram M. D.
Address Church Home Hosp Date signed 9/13/45

VS 180

Phyllis R. Ingram X

G32379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32379 Registered No. 93d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2545 W. Lombard St
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2545 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Burkert

3 (b) If veteran, name war

3 (c) Social Security Account No. 2-18-09-6438

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Liliane A. Burkert
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) May 11-1887

8. AGE: Years 63 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county and state)

10. Usual Occupation Night Watchman

11. Industry or business Night Watchman Security

FATHER
12. Name Fred'k W. Burkert
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Liliane A. Burkert
(b) Address 2545 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director F. B. Klippert Son
(b) Address Baltimore, Md

19 (a) (Date rec'd by local reg.) (b) Huntington, West Virginia, Md

SEP 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Sept 13 1945, and that I last saw h[illegible] alive on Sept 13 1945.

Immediate cause of death Coronary Disease — Duration 4 yrs

Due to

Due to

Other Conditions Arteriosclerotic C.V. Disease — 4 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. P. Jaborski M. D.
Address 5213 Bonnell Rd Date signed 9/13/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(33480) 183a

Registered No. (33480)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2117 Dennison

(c) Hospital or institution: Crawford Retreat 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 614 N. Eutaw St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Isabella Downey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/2/1856

8. AGE: Years 88 | Months 11 | Days — | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER 12. Name John Downey

13. Birthplace Ire

MOTHER 14. Maiden Name Lena Hartheim

15. Birthplace Ger

16 (a) Informant Robert E. Downey

(b) Address 814 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director F. D. Shipley & Son

(b) Address 301 Eastern Ave Milwaukee

19 (a) SEP 14 1945 (Date received by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945, at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Sept 12 1945, and that I last saw h[illegible] alive on Sept 12 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 9 mos.

Due to Generalized osteoporosis —

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at ..... M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury —

23. Signature Morris Blacker M. D.

Address 54 S. Fulton Ave Date signed 9-12-45

VS 180

G32381
XB-82178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G32381
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1651 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Joyce

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-4752

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 12- 1869

8. AGE: Years	Months	Days	If less than one day
75	11	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Press Operator for National
11. Industry or business Enameling & Stamping Co.

FATHER
12. Name John Joyce
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Connoll
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem. Co.
Location Balto. Co., Md.

18 (a) Funeral director A. Howard Grays
(b) Address 1400 N. Charles St.

SEP 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 12 1945, at 11.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21 1943 to 9-12 1945, and that I last saw him alive on 9-12- 1945

Immediate cause of death: Cutaneous Burns — Duration: 5 days
Due to: Wet heat
Due to: Benign prostatic hypertrophy with urine retention — ? yrs
Other Conditions: Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation 9-10-45
Major findings of operations: Supracondylar amputation for gangrene
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 7 1945 — 2 P.M.
(c) Where did injury occur? Baltimore City Hosp. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Burned in Salt Bath

23. Signature Thomas J. O'Neill M. D.
Address Balto City Hospitals Date signed 9-13-45

VS 150

TO BE APPROVED ***** BY MEDICAL EXAMINER Approved: Robert Lee Sutton M.D. Sept 13 1945

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32382
AB-93504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13f

G32382
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos-5days
(e) Length of stay in Baltimore (yrs., mos., or days) 33yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Milton Mercer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10-1908

8. AGE: Years	Months	Days	If less than one day
37	8	2	hr. min.

9. Birthplace N.J. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isiah Mercer (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Maude Winder
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.
18 (a) Funeral director Jos. Geo. H. Holland
(b) Address 1631 Eutaw Place
19 (a) (b) Huntington Williams, M.D.

SEP 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-12- 1945, at 5.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7- 1945 to 9-12- 1945 and that I last saw him alive on 9-12- 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: Dr. Calvert

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto City Hospitals Date signed 9-13-45

X

G32383 ✓ G32383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

24A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 259 S. Bond Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia D. Trice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1943

8. AGE: Years	Months	Days	If less than one day
2	0	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norman J. Trice
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Helen Mc Daniel
15. Birthplace Md.

16 (a) Informant Helen Trice
(b) Address 259 S. Bond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-45 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Taylor Ave.

18 (a) Funeral director Thos. A. Moran
(b) Address 3000 E. Balto. St.

19 SEP 14 1945 (b) Huntington Ave. Baltimore, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12- 1945; at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Septicemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 12 1945

VS 151

X

G32384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56

Registered No. G32384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6W day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. 25th Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? no years

3 (a) FULL NAME Verna Mae Jung

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or ~~wife~~ John Wm. Jung
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1898

8. AGE: Years	Months	Days	If less than one day
47	7	27	hr. min.

9. Birthplace Wrightsville, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel P. Keller
13. Birthplace Wrightsville, Pa.

MOTHER
14. Maiden Name Mamie Burkett
15. Birthplace Wrightsville, Pa.

16 (a) Informant Husband
(b) Address 1607 E. 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)
(c) Cemetery or crematory ~~XXX~~ Moreland Memorial Park
Location Taylor Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 SEP 14 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-45 19 , at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10 1945 to 9-11 1945, and that I last saw her alive on 9-11 1945.

	Duration
Immediate cause of death Cachexia	
Due to Ca. Fecal fistula following laparotomy for myoma	
Due to Ca of colon metastasis	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings: Uterine fibroids in first operation
Of operations Adhesions of bowel
at second operation
Of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerard E Brown M. D.
Address Md. General Hospital Date signed 9-11-45

VS 3

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32385

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 121

G32385 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ludus, Madison
(c) Hospital or institution: Md. General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3244 Abell Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edwina R. Trice

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband or~~ wife Alice Trice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 23rd 1895

8. AGE: Years	Months	Days	If less than one day
50	5	20	hr. min.

9. Birthplace Denton Md. (Town, county, and state)
10. Usual Occupation Guard
11. Industry or busin Lock Insulator Corp.

FATHER
12. Name Charles Trice
13. Birthplace Denton Md.

MOTHER
14. Maiden Name Dora Murphy
15. Birthplace Denton Md.

16 (a) Informant Alice Trice
(b) Address 3244 Abell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/45 (month) (day) (year)
(c) Cemetery or crematory Concord M.E. Church
Location Concord near Denton Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

SEP 14 1945 (Date received by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1945 12:59 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1945 to 9-13 1945 and that I last saw h. alive on 9-13 1945

Immediate cause of death: (a) Pulmonary Embolism
Due to:
Due to:
Other Conditions: Peritonitis from ruptured appendix
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations:
Of autopsy Pulmonary Embolism

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grace E Crouch M. D.
Address Md General Hospital Date signed 9-13-45

111a

G32386

HEALTH DEPARTMENT—CITY OF BALTIMORE

G32386

CERTIFICATE OF DEATH

954

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3123 Leeds St., Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Ella M. Staples

If U.S. Veteran specify WAR .....

(a) Residence: No. 3123 Leeds St., St., 20-6 Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Color	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) November 21, 1904

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
40	9 10	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housework

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore (State or country) Md.

FATHER

13. NAME Robert Staples

14. BIRTHPLACE (city or town) Scottsville, Va. (State or country)

MOTHER

15. MAIDEN NAME Janie Williams

16. BIRTHPLACE (city or town) Carroll, Balto. Co. Md (State or country)

17. INFORMANT Mr. Robert Staples.

(Address) 3123 Leeds St.

18. BURIAL, CREMATION, OR REMOVAL

Place Westminster Date Sept. 16, 1945

19. UNDERTAKER Mrs. Katie R. Williams

(Address) 322 N. Schroeder St.

20. FILED SEP 14 1945 Huntington Williams, Asst

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 12. 1945

22. I HEREBY CERTIFY, That I attended deceased from Sept 9 1945 to Sept 12 1945

I last saw her alive on Sept 11 1945 Death is said to have occurred on the date stated above, at 7.06 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Embolism	4 days
Rheumatic Heart Disease	
Decompensation of	3 Months
Other contributory causes of importance Hypertension	
Arteriosclerosis	Unknown

Was an operation performed? No Date of .....

For what disease or injury? .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Eliot W. Johnson M. D.

(Address) 343 Druid Pk

G32387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32387.

PRINTED WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Vine St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Clarence P. Joyce

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1894

8. AGE: Years	Months	Days	If less than one day
50	11	30	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

MOTHER / FATHER
12. Name James Joyce
13. Birthplace Eagles Mill, Md.
14. Maiden Name Ellen (Nellie) Stewart
15. Birthplace Nellie

16 (a) Informant Nellie Coleman (aunt)
(b) Address 824 Vine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15, '45 (month) (day) (year)
(c) Cemetery or crematory National
Location

18 (a) Funeral director Mrs. Katy R. Williams
(b) Address 322 N. Schroeder St

19 SEP 14 1945 (Date rec'd by registrar) Harrington-Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1945 at 10:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13, 1945, to Sept. 11, 1945, and that I last saw h[illegible] alive on Sept. 11 1945.

Immediate cause of death Ruptured abdominal Aortic Aneurysm — Duration: 6 days.
Due to Abdominal Aortic Aneurysm — Duration: 6 days.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Abdominal Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Provident Hospital Date signed 9/12/45

VS 180

G32388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83d

Registered No. G32388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER I. ASENDORF

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	215-10-8134

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Cecilia E. Asendorf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1885

8. AGE: Years	Months	Days	If less than one day
60	0	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Julius Gutman's

FATHER
12. Name John Asendorf
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Lerch
15. Birthplace Germany

16 (a) Informant Mrs. Cecelia E. Asendorf
(b) Address 1722 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 15 1945 (Date rec'd by Reg.) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 45, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 19 44 to Sept. 12 19 44, and that I last saw h[illegible] alive on Sept. 12 19 44

Immediate cause of death	Duration
acute myocardial insufficiency.	2 days
Due to hypertension	?
Due to	
Other Conditions right hemiplegia.	3 wks.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L C Schriel
Address 447 N. Kenwood Ave. Date signed 9/14/45 M. D.

932

632389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 632389

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 East St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mike Shalan

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-1801

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known ? 1880

8. AGE: Years	Months	Days	If less than one day
About 65			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Hotel work

11. Industry or business Lord Balto Hotel

FATHER
12. Name ? Shalan
13. Birthplace Russian

MOTHER
14. Maiden Name Not known
15. Birthplace Russian

16 (a) Informant Stella Koler
(b) Address 1929 E. East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-45 (month) (day) (year)
(c) Cemetery or crematory St. Andrew's Russian
Location Stoney Run and

18 (a) Funeral director John A. Grebliauskas Jr.
(b) Address 423 S. Paca St.

19 SEP 15 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1945 at 11:06 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratton M.D. (Medical Examiner)
Date signed September 13, 1945.

632390 See Births #26184 BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 632390

CERTIFICATE OF DEATH

158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Linden ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Linden ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-45

8. AGE: Years	Months	Days	If less than one day
	2	17	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 15 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

30

20. DATE OF DEATH August 31 1945, at 8 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Laceration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Baker M.D.
Medical Examiner.
Date signed Sept 1 1945

VS 151 2961

G32391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G32391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 So Linden ST.

(c) Hospital or institution: So. Balto General Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11d

(e) Length of stay in Baltimore (yrs., mos., or days) 11d

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County —

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 821 Jefferson ST.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Brown (Grace Beatrice)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/45

8. AGE: Years | Months | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Wm. Brown

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Rose Scarlette

15. Birthplace Baltimore Md

16 (a) Informant Rose Brown

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 14 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 45 at 5 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 19 45 to Sept 13 19 45 and that I last saw h[illegible] alive on Sept 13 19 45

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 201 Fort Ave. Date signed 9-13-45 M.D.

VS 190

2960

G32392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160C

Registered No. G32392

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 W. North ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hartman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Hospital for the Women of Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Herbert H. Hartman Jr.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Hazel Bernard Parker
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 3404 W. North Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL SEP 14 1945
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 15 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1945, to Sept 11 1945, and that I last saw him alive on Sept 11 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral damage.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. F. Jordan M. D.
Address Hospital for the Women of Md Date signed Sept 11, 1945

VS 150

F 2962

632393

B-95603

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137a

Registered No. 632393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 Melville Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Johnson

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26- 1869 ?

8. AGE: Years	Months	Days	If less than one day
75 ?	9 ?	17 ?	hr. min.

9. Birthplace England (Town, county and state)
10. Usual Occupation Butcher Retired
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace England

MOTHER
14. Maiden Name Mahoney
15. Birthplace England

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory St John's
Location Ellicott City Md
18 (a) Funeral director William Cook Dye
(b) Address 1217 E. Saratoga St

19 (a) SEP 15 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-13 19 45 at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22- 19 45 to 9-13 19 45, and that I last saw him alive on 9-13 19 45

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Pyelonephritis. Chronic	wks ?
Due to Benign Prostatic hypertrophy	yrs ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-29-45
Major findings of operation: BPH.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Cruell M. D.
Address Balto City Hosp Date signed 9-14-45

VS 150

X

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

G32394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G32394

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Magwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jack Magwood
13. Birthplace S. C.

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace S. C.

16 (a) Informant Rose Brooks
(b) Address 1030 Leadenhall St

17 (a) Removal (b) Date thereof 9-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Manning
Location S. C.

18 (a) Funeral director Isaiah L. Brunston
(b) Address 108 W Montgomery

19 SEP 15 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 19 45; at 11:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/9/45

VS 151

36214 G32395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56D

Registered No. G32395

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mexico (b) County
(c) City or town Mexico City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ninguna 7a
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carlos de Maza

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carmen Y. de Maza
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 4-30-1897

8. AGE: Years	Months	Days	If less than one day
48	4	14	hr. min.

9. Birthplace Mexico
(Town, county, and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name Antonio de Maza
13. Birthplace Mexico

MOTHER
14. Maiden Name Mercedes Flores Alatorre
15. Birthplace Mexico

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ French
Location Mexico City, Mexico

18 (a) Funeral director Arthur J. Mitchell
(b) Address 1900 Eutaw Place

19 (a) SEP 15 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1945 at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1945 to 9-14 1945; and that I last saw him alive on 9-14 1945

Immediate cause of death Metastatic Brain Tumor
Due to Pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

over

Date of operation 9/12/45
Major findings of operation Metastatic Brain Tumor
of autopsy: — St. Louis Encephalitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Williams
Address Johns Hopkins Hosp. Balto. Md. Date signed 9/14/45

VS 150

G32396

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 147 D

G32396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reynor + Dukeland Aves
(c) Hospital or institution: West. Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24d.
(e) Length of stay in Baltimore (yrs., mos., or days) 24d.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Woodward Dr (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE E. SAMPLE 31038

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Everett Sample

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1917

8. AGE: Years 28 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Albert York
13. Birthplace Md.

MOTHER 14. Maiden Name Mrs Adelaide
15. Birthplace Md.

16 (a) Informant Everett Sample
(b) Address 900 Woodward Drive - Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-45 (month) (day) (year)
(c) Cemetery or crematory Bush M.E. Cem
Location Bush Md.

18 (a) Funeral director Clarence Deaton
(b) Address Bush Md.

19 (a) (Date received by registrar) SEP 15 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1945 to 9/13 1945.
and that I last saw h. alive on 9/13 1945.

Immediate cause of death MASSIVE PULMONARY EMBOLISM

Due to PELVIC THROMBO PHLEBITIS

Due to CESAREAN SECTION FOR PLACENTA PRAEVIA

Other Conditions PREGNANCY + 23 DAYS POSTPARTUM.
(Include pregnancy within 3 months of death)

Date of operation 8/21/45

Major findings of operation: COMPLETE PLACENTA PRAEVIA

of autopsy: MASSIVE PULM. EMBOLISM

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Schlenfeld M. D.
Address West Balt Gen Hosp Date signed 9/13/45

632397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1922

Registered No. 632397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wladyslaw Zebrowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frances Zebrowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23/1883

8. AGE: Years	Months	Days	If less than one day
62 61	6	20	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Zebrowski

13. Birthplace Poland

MOTHER 14. Maiden Name Constance Modzelewski

15. Birthplace Poland

16 (a) Informant Frances Zebrowski

(b) Address 519 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred N. Ozazowski

(b) Address 1930 Eastern Ave.

19 (a) SEP 15 1945 (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1945 to Sept 10 1945 and that I last saw h alive on Sept 10 1945.

Immediate cause of death	Duration
acute dilatation of the heart	
Due to Endocarditis	
Due to Chronic Emphysema	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Sept. 13, 1945 at 6.45 PM M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marius Abramowicz M. D.

Address 1705 E. Balto. Date signed Sept 14. 1945

VS 150

G32398

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 93d

Registered No. G32398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 22 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7206 Holabird Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter G. Vesper
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1907

8. AGE: Years	Months	Days	If less than one day
37	11	23	16 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER
12. Name John A. Vesper (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Mary D. Hilmer (D)
15. Birthplace Germany

16 (a) Informant Mrs. John A. Vesper
(b) Address 7206 Holabird Ave. City 22

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 1945 (month) (day) (year)
(c) Cemetery or crematory Oakleaves
Location Dalta Md.

18 (a) Funeral director Harry A. Arrowood
(b) Address 4294 Pedgewood Ave.

SEP 15 1945 (Date received by Registrar) (b) Evington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1945, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1945 to Sept 14, 1945 and that I last saw him alive on Sept. 14 1945

Immediate cause of death (Cerebral hemorrhage) Cerebral vascular accident — Duration 7 days.
Due to Generalized arteriosclerosis
Due to
Other Conditions Hypertensive cardiovascular disease. — 3 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. Speach M.D.
Address Union Memorial Hosp. Date signed 9/14/45

VS 150

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Henry Hosp-tal / 10 -1
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1139 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Allan Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace E. Pealock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	11	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Missionary

11. Industry or business

FATHER
12. Name Wm W. Hoffman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna S Whittle
15. Birthplace Balto. Md

16 (a) Informant Mrs Anna E. Shipps
(b) Address 306 S. Catherine St

17 (a) Burial (b) Date thereof 9-15-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Harry A Witzke
(b) Address 4101 Edmondson Ave

Date rec'd by local registrar SEP 15 1945 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1945, at 4:22 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Lubarsky M.D.
Medical Examiner.
Date signed 9/15/45

VS 151

G32400 Hamburg

933 Hanover G32400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PRINT IN WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: Henry Herman Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna D. Stein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife late Adam A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Haesloop
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Heise
15. Birthplace Germany

16 (a) Informant Mr. George Waltz
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave + Longwood St

18 (a) Funeral director Harry H Wetzke
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by Registrar SEP 15 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20/45 to Sept. 13/45 and that I last saw her alive on Sept. 10/45.

Immediate cause of death — Duration

Angina Pectoris — 20 days

Due to Coronary Thrombosis. Unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Hoeck Chandler M. D.
Address 933 Hanover. Date signed Sept 13/45

VS 150

32101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered 32101

Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 430 S Bentalou Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Narcia P. May

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret Bowers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16, 1905

8. AGE: Years	Months	Days	If less than one day
40	-	28	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Bendix Radio

FATHER
12. Name Wm P. May
13. Birthplace South Carolina

MOTHER
14. Maiden Name Emma Helbig
15. Birthplace Penna

16 (a) Informant Mrs Margaret May
(b) Address 430 S. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Geary & Witzke
(b) Address 4101 Edmondson Ave
(Undertaker or Embalmer) (Huntington Williams M.D. Registrar)

SEP 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17/1945 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1945 to 9/17 1945
and that I last saw him alive on 9/14 1945.

Immediate cause of death	Duration
pulmonary Embolism	
Due to Aortic Stenosis & Heart Disease	
Due to Rheumatic Carditis Vascular disease	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl Pollitt Jr M. D.
Address St. Agnes Hosp Date signed 9/17/45

VS 150

G32402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32402 Registered No. 1222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Not known

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Crownsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Grinnage
3 (b) If veteran, name war No
3 (c) Social Security Account No.
4. Sex M
5. Color or race N
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Not known
8. AGE: Years 18? Months Days If less than one day hr. min.
9. Birthplace Not known (Town, county, and state)
10. Usual Occupation None
11. Industry or business
MOTHER / FATHER
12. Name Edward Grinnage
13. Birthplace —
14. Maiden Name Roberta Green
15. Birthplace —
16 (a) Informant Miss Ann Little
(b) Address Crownsville, Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15 45 (month) (day) (year)
(c) Cemetery or crematory Sharp St. Cemetary
Location Chase Md
18 (a) Funeral director Mrs. Robert A. Elliott & Dyl
(b) Address 1129 N. Caroline St
19 (a) SEP 15 1945 (Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1945, at 9.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945, to Sept 11 1945, and that I last saw h[illegible] alive on 9-11 1945.

Immediate cause of death Delayed post operative shock — Duration

Due to Strangulated hernia c gangrene of ileum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-10-45

Major findings of operation: Hernia c gangrene of ileum

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Tarlitz M. D.
Address 514 Division Date signed 9-11-45

Huntington Williams, M.D.

VS 150

G32403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G32403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 0 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Brohawn Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Bergen

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia Marie Bergen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1887

8. AGE: Years 58 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Clothing Cutter

11. Industry or business Belmont Trouser Co.

FATHER
12. Name Benjamin M. Bergen
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine McWhorter
15. Birthplace Md.

16 (a) Informant Mrs. Virginia M. Bergen
(b) Address 2414 Brohawn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) SEP 15 1945 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1945, at (a) 35 M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 13 1945 25-2 10 P.M.
(b) Where did injury occur In front of 2806 Hollingsworth Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Fraker M.D. Medical Examiner.
Signed 9-14-45

X

G52404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G52404

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Francis Riordan

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Beatrice Riordan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1906

8. AGE: Years	Months	Days	If less than one day
39	0	12	hr. min.

9. Birthplace Libertytown, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Western Electric Co.

FATHER
12. Name John T. Riordan
13. Birthplace Libertytown, Md.

MOTHER
14. Maiden Name Margaret Collins
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. John T. Riordan
(b) Address 1022 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem. Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) SEP 15 1945 Registrar

VS 151

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1945, at 6:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dis death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bracken M.D. Medical Examiner.
Date signed 9-14-45

X

G32405
480320

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 194

G32405
Registered No.

THIS WHITE PEANDY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Birmingham
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Empire Building
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Watterston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Dr. Lafayette Watterston
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 11-26-83

8. AGE: Years	Months	Days	If less than one day
61 63	9	19	hr. min.

9. Birthplace Ky.
(Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER 12. Name James Ferguson.
13. Birthplace Ky.

MOTHER 14. Maiden Name Parham Mornington
15. Birthplace Ky

16 (a) Informant Recds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/15/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3501 Frederick Ave

18 (a) Funeral director Colonel Mitchell & Sons
(b) Address 1900 Eutaw Pl.

19 SEP 15 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1945, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1945, to Sept 15 1945, and that I last saw her alive on Sept 15 1945.

Immediate cause of death Lymphangiitis adenitis — Duration 5 days
Due to Spider bite
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation:
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Spider bite
(b) Date of occurrence Sept 8 at V-01 P M
(c) Where did injury occur? Birmingham Ala
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work?
(Specify type of place)
(e) Means of injury

23. Signature Warfield M. Firor M. D.
Address J H Hosp
Date signed Sept 15 '45

VS 150

G32406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G32406

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 MONTPELIER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 MONTPELIER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES J. MANION

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: AGNES MANION
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN 1870

8. AGE: Years: ABOUT 75 | Months | Days | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business BALTO. CITY

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant CATHERINE SMALLWOOD (FRIEND)
(b) Address 1107 MONTPELIER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 17/45 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1 S. WOLFE ST.

19 (a) SEP 15 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar
(b)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 14 19 45 at 6/10 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 20 1945 to Sept-14 1945. and that I last saw him alive on Sept 14 - 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 weeks
Due to: Arterio Sclerosis — 0 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E North Av Date signed 9/15/46 M. D.

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32407 X G32407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No.

Every item of information should be carefully supplied. The name of the deceased, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Do not put
(c) City or town Ewell, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WALLACE EVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Winnie L. Tyler
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 20, 1901

8. AGE: Years	Months	Days	If less than one day
44	3	24	____ hr. ____ min.

9. Birthplace Ewell, Maryland
(Town, county, and state)
10. Usual Occupation Waterman
11. Industry or business

FATHER
12. Name W. Wallace Evans
13. Birthplace Ewell, Maryland

MOTHER
14. Maiden Name Minnie Hall
15. Birthplace Fairmount, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof Sept 16 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ewell Cem
Location Ewell Md.
18 (a) Funeral director H. Harvey Bradshaw
(b) Address Crisfield, Md.

SEP 16 1945 Huntingtown Williams, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1945, at 9:20p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12, 1945, to Sept. 14, 1945, and that I last saw him alive on Sept. 14, 1945

Immediate cause of death	Duration
Rheumatic heart disease with cardiac insufficiency	Unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. Wilson
J. L. Wilson, Sr. Surgeon, USPHS
Address Clinical Director Date signed 9/15/45 M. D.

VS 150

X

G32408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 74A

G32408
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HILDA F. ZARRO

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1899

8. AGE: Years	Months	Days	If less than one day
46	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Baccio Formi
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Antonio Zarro
(b) Address 2910 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon Park, Cemetery
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM J. TICKNER & SONS.
(b) Address Baltimore, Maryland

SEP 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1945, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 30 1945 to Sept 14 1945 and that I last saw alive on Sept 14 1945.

Immediate cause of death: Acute myeloid leukemia — Duration: 4 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grant S. Rabe M. D.
Address 735 Pop Dr. Dr. Date signed 9/16/45

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 E

G32409 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3102 Abell Ave.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Abell Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME White, Mary Mrs. Ernest Edward Schultz

3 (b) If veteran, name war — No
3 (c) Social Security Account No. — No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mr. Ernest E.
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) July 18, 1909

8. AGE: Years	Months	Days	If less than one day
36	1	29	7 hr. 45 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name George Constantine
13. Birthplace South America

MOTHER
14. Maiden Name Mary M. Craig
15. Birthplace Maryland

16 (a) Informant Ernest E. Schultz
(b) Address 3102 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

SEP 16 1945 (b) (Date received by Registrar) Registrar

Hunting for Hillcrest, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12th 1945 to Sept 15 1945, and that I last saw h-r alive on Sept 15th 1945.

Immediate cause of death	Duration
Intestinal Obstruction	4 mos
Due to Abdominal Carcinomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 10th 1945
Major findings of operation: Intestinal obst. due to carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kieb[illegible], Jr. M. D.
Address Union Memorial Hosp. Date signed 9-15-45

VS 150

X

G32410 BALTIMORE CITY HEALTH DEPARTMENT G32410
Registered No.

CERTIFICATE OF DEATH 119A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. Carrollton ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Canoles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1944

8. AGE: Years	Months	Days	If less than one day
	8	27	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name Frederick Canoles
	13. Birthplace Baltimore Md.
MOTHER	14. Maiden Name Edith Hessler
	15. Birthplace Baltimore, Md.

16 (a) Informant Mr Frederick Canoles
(b) Address 122 S Carrollton Ave
17 (a) burial (b) Date thereof 9/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location End of E North Ave
18 (a) Funeral director John J Coward & Son
(b) Address 901-03 W Lanvale St
19 (a) 16 1945 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1945 at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Pneumonia Influenza

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A Gruber M.D.
Medical Examiner.
Date signed September 14, 1945

X

G32411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G32411 Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Penrose Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Penrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rose Veronica Wortman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gorman E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 23, 1918

8. AGE: Years 27. Months 4 Days 21 If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Lawrence L. Lehser
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Rose Murray
15. Birthplace Baltimore Md

16 (a) Informant W. Gorman E. Wortman
(b) Address 2232 Penrose Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Fulton St

Date rec'd by registrar 9/16/1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1945 to 9-13 1945 and that I last saw h[illegible] alive on 9-12 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M.D.
M. D.
Address Bon Secours Date signed 9-13-45

VS 150

G32112 G32412

AB-96035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs-40min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3893

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9- 1883

8. AGE: Years	Months	Days	If less than one day
62	7	4	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Frank Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mickelina Barzak
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Dundalk Ave

18 (a) Funeral director STEPHEN J. FIALKOWSKI
(b) Address 1000 S. Kenwood ave

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-13- 1945, at 2.10PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12- 1945 to 9-13- 1945, and that I last saw him alive on 9-13- 1945.

Immediate cause of death Hemorrhage from esophageal varices — Duration

Due to Cirrhosis of liver

Due to

Other Conditions Hypertensive cardiovascular

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Hovland M. D.
Address [illegible] Date signed 9/14/45

VS 150

Subject to approval of Medical Examiner Leakeas, M.D.

CAUTION: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 186 B

G32433

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 26

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 S. Potomac ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Foley

3 (b) If veteran, name war: World I - British
3 (c) Social Security Account No. 212-18-8348

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife: Stella Foley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1891

8. AGE: Years	Months	Days	If less than one day
53	9	6	hr. min.

9. Birthplace London England. (Town, county, and state)
10. Usual Occupation Laborer
11. Employer Ky Highway

FATHER
12. Name Wm Foley
13. Birthplace London England

MOTHER
14. Maiden Name Mary
15. Birthplace London England.

16 (a) Informant Mrs. Stella Foley
(b) Address 803 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17 45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location North Ave

18 (a) Funeral director Stephen J. Fralkowski
(b) Address 1000 N. Renwood Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

SEP 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1945 at 12 P M

21. I certify that I took charge of the remains described above, held an Inquestion Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed body; Compound comminuted fracture of arms & legs comminuted

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 26-6
(a) Date of injury Sept. 14 1945 11 45 A.M.
(b) Where did injury occur Gittman's Pier, Boston St.
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? yes
(d) Means of injury Crushed between crane & platform

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Sept. 14 1945

G32414 G32414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) More than 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley Balt. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Louise Marie Hensley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1904

8. AGE: Years	Months	Days	If less than one day
41	4	2	hr. min.

9. Birthplace Louisville, Kentucky (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business Sister of the Poor

FATHER
12. Name Albert Hensley
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary Kleber
15. Birthplace Kentucky

16 (a) Informant Mother Ignatius
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 9 1/2 Conway corner Arch
(c) Huntington Building, Md.

16 1945
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16/ 1945, at 2:43 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1945 to 9/15 1945, and that I last saw her alive on 9/14 1945.

	Duration
Immediate cause of death Uremia	
Due to Kidney Disease	8/4/45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Bailey M. D.
Address Mercy Hosp. Date signed 9/16/45

VS 150

G32415 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G32415

CERTIFICATE OF DEATH

131 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 Rosemont Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Rosemont Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Estelle Rosenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Francis G. Rosenfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1867

8. AGE: Years 78 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bourbe
13. Birthplace ?

MOTHER
14. Maiden Name J. Leo Rosenfeld
15. Birthplace Balto.

16 (a) Informant Francis G. Rosenfeld
(b) Address 3810 Rosemont Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto.

18 (a) Funeral director Rita Windfeld
(b) Address 914 Fremont Ave

19 (a) [illegible] Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Sept 14 1945; and that I last saw him alive on Sept 14 1945.

Immediate cause of death: Arteriosclerosis — Duration 3½ yrs

Due to Cerebral Vascular Renal Disease — 3½ yrs

Due to Hypertension — 3½ yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanagh M.D.
Address 33 W. McCulloh St Date signed Sept 15-45

VS 150

632416 BALTIMORE CITY HEALTH DEPARTMENT 632416

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4629 Schenley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4629 Schenley Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth L. Rohr
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles N. Rohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1887

8. AGE: Years 61 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James F. Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie E. Bailey
15. Birthplace Maryland

16 (a) Informant Charles N. Rohr
(b) Address 4629 Schenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Maria Chapel
Location Baltimore, Maryland

18 (a) Funeral director Burdee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 16 1945 (b) Registrar
(Date rec'd by registrar) Penning for Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1945, at 1:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 14 1945, and that I last saw h alive on Sept 14 1945.

Immediate cause of death Coronary Thrombosis — Duration 24 hrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gibson Porter M. D.
Address 4822 Roland Ave Date signed 9/15/45

X

G32417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G32417 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Aberdeen - (If outside city or town limits, write RURAL and give town)
(d) Street No. Aberdeen Proving Ground (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Ferguson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, '45

8. AGE: Years — Months — Days 1 If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name Jarrel Ferguson

13. Birthplace Kentucky

14. Maiden Name Bernice ?

15. Birthplace Kentucky

16 (a) Informant Records -

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17/45 (month) (day) (year)

(c) Cemetery or crematory Pamtarville

Location Kentucky

18 (a) Funeral director George L. Schwartz

(b) Address 2101 Frederick Ave

19 (a) (b)
(Signature of registrar) Registrar

EP 16 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1945 at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Sept 16 1945 and that I last saw h[illegible] alive on Sept 16 1945

Immediate cause of death — Duration

Prematurity —

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Romona Hickey Hall Asst Res, M.D.

Address Hopkins Hospital Date signed 9-15-45.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32418 MAMIE L. G32418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 201 Beechfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Beechfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie L McLaughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color [redacted]

6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 31 1879

8. AGE: Years 65 | Months 10 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name William J McLaughlin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary L Doyle
15. Birthplace Baltimore Md

16 (a) Informant E. McManee
(b) Address 201 Beechfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3060 E Baltimore St

19 (a) 1945 (Filed by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1941 to 9-15 1945 and that I last saw h[illegible] alive on 9-15 1945

Immediate cause of death: Coronary Thrombosis — Duration 24 hrs.
Due to: Cardia-Vascular Dis — 5 yr?
Due to: Cancer of Bull Bladder — 2 yr?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Moran M. D.
Address 602 23rd Date signed 9-18-45
Catonsville Md. 2 Ave & Oliver

VS 150

G32419

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186A

G32419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 29 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Millard M. Legg

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-3162

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-8-1886

8. AGE: Years	Months	Days	If less than one day
59	8	5	hr. min.

9. Birthplace Belair, Md. (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business Rail Car Loading Co.

FATHER
12. Name Will Legg
13. Birthplace Belair, Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Annie Legg
(b) Address 29 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) 9 (Day) 11 (Year) 45
(c) Cemetery or crematory Mem. Cath. Cem.
Location Old Frederick Rd.

18 (a) Funeral director Edgar A. Judson
(b) Address 3004 Eastern Ave. (Penning or Williams, M.D.)

19 (a) 9-12-1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1945 at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1945, to Sept. 13, 1945, and that I last saw him alive on Sept. 13, 1945.

Immediate cause of death Subdural hemorrhage due to fractured skull ? hemorrhage into temporal lobe & left eye

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/10/45

Major findings of operation: Laceration of left frontal lobe of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accidental
(b) Date of occurrence 9-8-45 at 6-1 M
(c) Where did injury occur? 3rd floor, Fairmont & pole Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)
(e) Means of injury Fell to sidewalk while intoxicated

23. Signature Albert G. Moss M. D.
Address Sinai Hospital Date signed 9/13/45

Approved: Robert Lee Sutton M.D.

VS 150

G32420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

Registered No. G32420

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Colmot Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 17 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Charles Alonzo Quengel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Eva Sickle Quengel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/03

8. AGE: Years	Months	Days	If less than one day
41	2	10	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Henry Quengel
13. Birthplace West Virginia

MOTHER
14. Maiden Name Margaret Peden Hunter
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Eva Sickle Quengel
(b) Address 1216 Bolton St, City 17

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept 16 45 (month) (day) (year)
(c) Cemetery or crematory Rennert
Location Mountmorris Pa. Via Jones L. & L. R.R.

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave

19 (a) P 17 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16, 1945, at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1945, to Sept 16 1945, and that I last saw him alive on Sept. 16 1945.

Immediate cause of death Carcinomatosis — Duration

Due to Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Speed III M.D.
Address Union Mem. Hosp. Date signed 9/16/45

VS 150

G324421
HEP #95943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G324421
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 N. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Amos

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Robert Lee Amos (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1871

8. AGE: Years 74 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Elias James Gornell (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Vanpelt (d)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory Frankenville
Location Baltimore Co. Md.

18 (a) Funeral director Tillson & Son
(b) Address 1217 E. Fort Ave

19 (a) 7 1945 (Date not to be filled in by registrant) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 14, 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8, 1945, to Sept. 14, 1945, and that I last saw her alive on Sept. 14, 1945.

Immediate cause of death: cerebral thrombosis
site unknown
Due to: Arteriosclerosis ?
Due to: uremia
Other Conditions: Cardiac Failure
Bronchopneumonia
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy: not yet available

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B E H Date signed 9/18/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 462 Registered 632422

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 909 N Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Arenz

3 (b) If veteran, name war: World I
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 30 1892
8. AGE: Years 53 Months 2 Days 14 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Mechanical
11. Industry or business B&O R.R.

FATHER
12. Name John Arenz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Dot
15. Birthplace Germany

16 (a) Informant Mrs Anna Arenz
(b) Address 909 N Chester St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Wilhelm Bork Inc
(b) Address 1219 E Pratt St
SEP 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945 at 10 40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945, to 9/14 1945, and that I last saw him alive on 9/13 1945.

Immediate cause of death: Cerebral hemorrhage
Due to: Hypertension
Due to: Malignant neoplasm (new)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 1123 E Pratt St Date signed 9/14/45 M. D.

VS 180

HASKELL-D-Franklin

G32423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G32423

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 N. Calhoun St
(c) Hospital or institution: DOA

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1720 N. Calhoun St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	C	married

6 (b) Name of husband or wife Nellie Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1887

8. AGE: Years	Months	Days	If less than one day
57	58		hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Nellie Coleman
(b) Address 1720 N. Calhoun St

17 (a) Burial (b) Date thereof 9-19-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Wash D.C.
Location D.C

18 (a) Funeral director George G. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar)

SEP 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1945, at 11:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection-Inquiry thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertension C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Rubenstein M.D.
Medical Examiner.

Date signed 9/16/45

X

G32424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32424

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Dukeland Sts.
(c) Hospital or institution West Balto. Gen Hosp. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 14d.
(e) Length of stay in Baltimore (yrs., mos., or days) 14d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME BABY GIRL HARRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 8-31-45

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days 14 15 | If less than one day ..... hr. ..... min.

9. Birthplace W. B. D. H. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name unknown
13. Birthplace .....

MOTHER
14. Maiden Name Rosalie Harris
15. Birthplace Waterbury, Conn.

16 (a) Informant .....
(b) Address .....

17 (a) ..... (b) Date thereof ..... (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1945

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 SEP 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1945, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1945 to 9/14 1945, and that I last saw h[illegible] alive on 9/14 1945.

Immediate cause of death Atelectasis

Due to .....

Due to .....

Other Conditions PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at .....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature A. Lilienfeld M. D.
Address West Balto. Gen. Hosp. Date signed 9/14/45

VS 150

2964

Names must be PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G-32425

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G32425
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Calhoun St
(c) Hospital or institution: Franklin Sq. Hosp Newborn
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 W. Fayette
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hillman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	w	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-45

8. AGE: Years	Months	Days	If less than one day
		1	7 hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Robert Hillman
13. Birthplace

MOTHER
14. Maiden Name Isabelle Thompson
15. Birthplace New York

16 (a) Informant Mrs Isabelle Hillman
(b) Address 1806 W. Fayette

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 17 1945 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 - 1945, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1945 to 9-14 1945 and that I last saw her alive on 9-14 1945

Immediate cause of death Congental heart disease — Duration 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bentley Gaines M. D.
Address Franklin Square Hosp Date signed 9-14-45

VS 150

2965

G32426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1114C

G32426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 N. Dawale
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1528 N. Dawale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2. 1885

8. AGE: Years 59 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Fernina Fla (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Brown
13. Birthplace Fla

MOTHER 14. Maiden Name Louisa Williams
15. Birthplace Fla.

16 (a) Informant Mary Lewis
(b) Address 1528 N. Dawale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park Co
Location

18 (a) Funeral director Sam'l. H. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) (b) Registrar
(Date received by Registrar) SEP 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1945 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9, 1945 to Sept 14, 1945, and that I last saw h. alive on Sept 14, 1945

Immediate cause of death Chronic pulmonary abscess — Duration 3 yrs

Due to

Due to

Other Conditions Gangrene of leg (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. & J. Camper M. D.
Address 639 N. Carey St Date signed 9-15-45

Huntington Williams, M.D

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G32427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

Registered No. G32427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2713 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Arnold

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna R. Arnold
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) July 4, 1883
8. AGE: Years 62 | Months 2 | Days 15 | If less than one day: hr. min.
9. Birthplace Anne Arundel Co Md (town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Dept. of Education

FATHER
12. Name John R. Arnold
13. Birthplace [illegible] Md

MOTHER
14. Maiden Name Mary E. McCall
15. Birthplace Balto. Md

16 (a) Informant Charles Board
(b) Address 2713 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Balto Md.

18 (a) Funeral director C. Board Evans
(b) Address 1402 E. Chase St.

19 (a) (b)
(Date received by registrar) SEP 17 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1945, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Sept 16 1945, and that I last saw h[illegible] alive on Sept 15 1945.

Immediate cause of death: Hodgkins Disease — Duration: 9 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Mosser M. D.
Address 3104 Belair Rd Date signed 9-17-45

G324128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G324128

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green

(c) Hospital or institution: University Hospital 17-1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 7 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balt.

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 561 Bidde St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Sadie Evelyn Beatrice Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1944

8. AGE: Years	Months	Days	If less than one day
1	7	6	hr. min.

9. Birthplace 1352 Stockton St, Balt, (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kelly Vaughn

13. Birthplace Savannah, Ga.

MOTHER 14. Maiden Name Thelma Gibson

15. Birthplace Baltimore, Md.

16 (a) Informant Mother

(b) Address 561 Bidde St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead

(b) Address 1918 Druid Hill Ave.

19 (a) SEP 17 1945 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1945, to Sept. 14 1945, and that I last saw h er alive on Sept 14 19 45.

Immediate cause of death Tuberculous meningitis — Duration

Due to Miliary T.B.c.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G B Laney M. D.

Address Univ. Hosp. Date signed 9-14-45

G32429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32429 Registered No.

131A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 Colvin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Colored	Female	Married

6 (b) Name of husband or wife Robert Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Farmville Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknow
13. Birthplace "

MOTHER
14. Maiden Name Unknow
15. Birthplace "

16 (a) Informant Mary Brown
(b) Address 143 Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetary
Location Cedarhill Md.

18 (a) Funeral director Solophus Hayden
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by Registrar) 9-14-45 (b) Registrar

VS 151 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12 1945, at 8 53 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cirtus tuberculosis
Cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 9-13-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item or information should be carefully supplied. The

632430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 158

Registered No. 632430

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 W. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 W. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-45

8. AGE: Years	Months	Days	If less than one day
	3 yr	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace S.C.

MOTHER
14. Maiden Name Helen Stewart
15. Birthplace S.C.

16 (a) Informant Helen Jones
(b) Address 519 W. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Holyfield
(b) Address 918 Reed St. Balto.

19 (a) SEP 17 1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1945, at 7:4 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D. Medical Examiner.
Date signed Sept. 16 1945

X

G32431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G32431

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SOUTH BALTIMORE GEN. HOSP. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 LAKE AVENUE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT HIGH ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 21ST 1866 ✓

8. AGE: Years	Months	Days	If less than one day
78	04	24	hr. min.

9. Birthplace BALTIMORE - MD.
(Town, county, and state)
10. Usual Occupation UPHOLSTERER.
11. Industry or business

FATHER
12. Name WM. HIGH
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name EUGENIA WEHRETT
15. Birthplace BALTO. MD.

16 (a) Informant John L. Page
(b) Address 2231 Lake Ave

17 (a) Burial (b) Date thereof Sept 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location City

18 (a) Funeral director Wenck Funeral Home
(b) Address 2008 Orleans St

19 (a) Filed by registrar SEP 17 1945 Huntington Washington, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 15 1945 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 4 1945 to SEPT 15 1945 and that I last saw HIM alive on SEPT 15 1945

Immediate cause of death	Duration
LOBAR PNEUMONIA	
Due to HEART FAILURE	2 DAYS
Due to MALNUTRITION & DEHYDRATION	8 DAYS
Other Conditions CA OF COLON	?

(Include pregnancy within 3 months of death)
Date of operation SEPT. 7TH 1945
Major findings of operation: CARCINOMA OF COLON - SPLENIC FLEXURE
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos E Wheeler M. D.
Address South Balto Gen Hosp Date signed Sept 15, 1945

VS 150

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G32432 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3511 Cedardale Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

15 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3511 Cedardale Road.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE SCHLOSS DIENER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Samuel Diener.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1864.

8. AGE: Years	Months	Days	If less than one day
81	0	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Moses Schloss,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Germany.

16 (a) Informant Dr. Louis Diener,
(b) Address Biltmore Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.18.45. (month) (day) (year)
(c) Cemetery or ~~crematory~~ Hebrew Friendship.
Location Baltimore, Md.

18 (a) Funeral ~~director~~ Samuel Levin & Son
(b) Address 1902 Eutaw Place.

19 (a) SEP 17 1945 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16th. 1945 at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Sept 16 1945, and that I last saw her alive on Sept 16 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to	
Due to Arterio-sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lutz M. D.
Address Temple Garden Apts Date signed 9.16.45

X

632-433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

632433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. TEMPLE GARDEN APTS
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. HENRY WILDMAN MACKS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 30, 1888

8. AGE: Years	Months	Days	If less than one day
56	9	14	hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name DAVE MACKS
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name RAY WILDMAN
15. Birthplace RUSSIA

16 (a) Informant Mrs. Lavinia
(b) Address Greensboro N. C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) ~~Cemetery or crematory~~ Woodlawn Park
Location Baltimore, Md.

18 (a) Funeral Baird Sondheim & Co.
(b) Address 1 90 2 Eutaw Place

19 (a) SEP 18 1945 (Date received by registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 14 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 6 1945, to SEPT. 14 1945, and that I last saw him alive on SEPT 13 1945.

Immediate cause of death	Duration
BRONCHOPNEUMONIA	
Due to CHRONIC LYMPHATIC LEUKEMIA	
Due to	
Other Conditions LEUKEMIA DERMATITIS CUTIS.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 9-14-45

VS 150

G32434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G32434

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3229 Abell Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Abell Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Emma Landbeck

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Femal
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife: Louis G Landbeck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-24-1863

8. AGE: Years 82 | Months 7 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business None

FATHER
12. Name Conrad Krantz
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Holzner
15. Birthplace Germany

16 (a) Informant Mr. Harry J. Landbeck
(b) Address 3514 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17/45. (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Avenue

18 (a) Funeral director Jos. Joerdens & Son
(b) Address 1927 Park Ave., City.

19 (a) ____ (Date received by registrar) (b) ____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1945, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8/ 1945 to 9/14/45, and that I last saw h[illegible] alive on 9/13/ 1945.

Immediate cause of death: Cardio-vascular renal diseases. — Duration: 7 days
Due to: ____
Due to: ____ — 48 hrs.
Other Conditions: Bronchopneumonia —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. A. Barden
Address 1517 E. North Ave. Date signed 9/15/45.

SEP 17 1945 Huntington Williams, M.D.

VS 180

G32435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1930

G32435
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 E. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Carlisle

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Alexander Carlisle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1861

8. AGE: Years	Months	Days	If less than one day
84	4	29	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry P. Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Clara T. Carlisle
(b) Address 2116 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location North Ave & Rose Sts

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) (Date rec'd by registrar) (b) Huntington Hills Registrar

SEP. 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1945 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1945 to Sept. 15 1945. and that I last saw her alive on Sept. 15 1945.

Immediate cause of death	Duration
Arteriosclerosis	
Chronic Myocarditis.	5 yrs
Cholecystitis	15 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred DeSingmald
Address 1613 E. North Ave. Date signed 9-16-45

G32436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

G32436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 W Franklin St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Curtis Savage
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife Temple Savage
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1901

8. AGE: Years	Months	Days	If less than one day
43 44	11	2	hr. min.

9. Birthplace Accomac Co Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Custis
13. Birthplace Accomac Co Va

MOTHER
14. Maiden Name Anna Parker
15. Birthplace Accomac Co Va

16 (a) Informant John Custis
(b) Address 1111 W Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17, 1945 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 212 N Schroeder St.

19 (a) (b)
(Date received by registrar) SEP 17 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 13 1945 and that I last saw ha alive on Sept 13 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Watts
Address 5154 Wilkens Ave Date signed 9/15/45

Spec.—6-9-19—H. P. Co.—1000 Blks.

G32437

G32437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 95C

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N. Fremont Ave ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sharp

(a) RESIDENCE. No 115 N. Fremont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Sharp

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Robert Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Sedonia Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chester Co. Md

14 Informant Rebecca White

(Address) 115 N Fremont Ave

15 SEP 17 1945 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1945

17 I HEREBY CERTIFY, That I attended deceased from Sept 7 -45 to 9-13-45 19

that I last saw her alive on " 19

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chron. Cardiac Disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? O

Did an operation precede death? O Date of

Was there an autopsy? O

What test confirmed diagnosis?

(Signed) Jno Cardozo M. D.

19 (Address) 1524 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 9/16/45 19

20 UNDERTAKER Mrs Katie R Williams ADDRESS 322 N Schroeder

TION is very important. See instructions on back of certificates.

G32438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G32438

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Estephine Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Myrtle Hall Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1913

8. AGE: Years	Months	Days	If less than one day
32	6	10	hr. min.

9. Birthplace Anderson, S. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Zuitman Scott
13. Birthplace Anderson, S. C.

MOTHER
14. Maiden Name Ida Whitten
15. Birthplace Anderson, S. C.

16 (a) Informant Mrs. Myrtle Hall Scott
(b) Address 1121 Harlem Ave.

17 (a) Burial (b) Date thereof Sept. 17 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 17 1945 Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1945, at 8 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured aneurysm of aorta
Due to Luetic CVD

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B Shuham M.D.
Medical Examiner.
Date signed 9/13/45

VS 151

G32439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G32439

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 W. 39th Street
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 W. 39th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lucie Margaret Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Benjamin Franklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1855

8. AGE: Years	Months	Days	If less than one day
89	11	19	hr. min.

9. Birthplace New York, N. Y.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Gustave L. Schiff
13. Birthplace Paris - France

MOTHER
14. Maiden Name Margaret O. Colt
15. Birthplace Baltimore

16 (a) Informant Margaret O. Cromwell
(b) Address Brightside Rd. Balto. 12

17 (a) Cremation (b) Date thereof 9-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Henry W. Jenkins Sons
(b) Address McCulloh & Orchard

19 SEP 17 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to Sept. 16 1945, and that I last saw her alive on Sept. 16 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to hypertension & arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charlotte McCarthy M. D.
M. D.
Address Medical Arts Bldg. Date signed Sept. 16 1945
Baltimore Md.

VS 150

G32440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133 A

G32440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Bova

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Santa V. Boda
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1891
8. AGE: Years 54 | Months | Days | If less than one day hr. min.
9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Janitor
11. Industry or business: Baltimore City

FATHER
12. Name: Joseph Bova
13. Birthplace: Italy

MOTHER
14. Maiden Name: Clara Scalia
15. Birthplace: Italy

16 (a) Informant: Mrs Clara V. Bova
(b) Address: 1127 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore

18 (a) Funeral director: Frederick A. Cox
(b) Address: 2200 Lombard St.

19 (a) (Date received by local registrar) SEP 17 1945 (b) Huntington Williamsville Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14th 1945, at 9:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 15 1945 to Sept 14 1945, and that I last saw h[illegible] alive on Sept 14 1945.

Immediate cause of death: Chronic Pyelonephritis — Duration 10 yrs
Due to:
Due to:
Other Conditions: Chronic Tonsilitis — Duration 4 mo.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: C. P. Lubinski M. D.
Address: 6217 Yarmouth Rd Date signed 9/15/45

VS 180

632441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117-A

Registered No. 632141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Bon Secours Hospital
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) Life

USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 W Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fletcher Collins

3 (b) If veteran, name war None

3 (c) Social Security Account No. 213-12-1025

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marie A. Collins

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1889

8. AGE: Years 55 | Months 10 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation machinist

11. Industry or business

FATHER
12. Name Rev. Thomas D. Collins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Estelle Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Marie A. Collins
(b) Address 2007 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Rider
Location Walks, Blvd. Elmridge

18 (a) Funeral director Frederick A. Cole
(b) Address 206 N. Lombard St.

19 (a) SEP 17 1945 (Date rec'd by Registrar) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1945 at 4 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1945 to 9-13 1945 and that I last saw him alive on 9-13 1945

Immediate cause of death Gastric Hemorrhage, — Duration 48 hrs.
Due to Peptic ulcer
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: Peptic ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 9/13/45

VS 150

632442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 632442

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Spaulding Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) S

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Spaulding Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schlaffer,

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Magdalena Schlaffer,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1859

8. AGE: Years	Months	Days	If less than one day
86	1	12	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Retired,
11. Industry or business

FATHER
12. Name Frank Schlaffer,
13. Birthplace Germany,

MOTHER
14. Maiden Name Itzel,
15. Birthplace Germany,

16 (a) Informant Mrs. Charles Schlaffer,
(b) Address 3621 Spaulding Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.,
Location Baltimore City.

18 (a) Funeral director Vernon Lemmon
(b) Address 4611 Park Heights Ave.

SEP 17 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1945, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Sept 15 1945, and that I last saw him alive on July 22 1945.

Immediate cause of death
Died in his sleep.
Due to Chr General Arterio-sclerosis
Due to Old age
Other Conditions
(Include pregnancy within 3 months of death)

Duration
Several years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Keown M. D.
Address 1938 Linden Ave. Date signed 9/17/45

VS 150

632443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

Registered No. 632443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12N MONROE STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20'
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 12N MONROE STREET (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET SCHMIDT

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JAN. 26 1861

8. AGE: Years	Months	Days	If less than one day
84	7	21	hr. min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation NEVER EMPLOYED
11. Industry or business

FATHER
12. Name JACOB SCHMIDT
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ✓

16 (a) Informant MRS. WILLIAM C. SCHMIDT
(b) Address 12N MONROE STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 18-45 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM.
Location EDMONDSON AVENUE

18 (a) Funeral director G. CHESTER WEBER
(b) Address 2503 EDMONDSON AVE

19 SEP 17 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 15 1945 at 10:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 24 1941 to SEPT. 15 1945 and that I last saw her alive on SEPT. 15 1945.

Immediate cause of death CELLULITIS OF FACE
BACTERICEMIA.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration 12 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel G. Bogorad M.D.
Address 1905 W. Baltimore St. Date signed 9/17/45

VS 150

632444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

632444 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glenwood Collins

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-2422

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Ellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-10-22

8. AGE: Years	Months	Days	If less than one day
23	2	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Norman Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Manie Collins
15. Birthplace Md.

16 (a) Informant Manie Collins
(b) Address 819 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 364 N. Central Ave
(c) Huntington Williamsport

SEP 17 1945
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1945 at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 13 1945, and that I last saw him alive on Sept 13 1945.

Immediate cause of death	Duration
Acute cardiac decompensation	
Due to mitral insufficiency	
Due to Pulmonary Tuberculosis Cavernous	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert E. Bennett M. D.
Address 121 A. Sq. W. Th Date signed 9/16/45

VS 150

G32445

MP #95926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

G32445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 McCubbin St.
(e) Citizen of foreign country (If not give location)
If yes, name country (Yes or No)

3 (a) FULL NAME Ben Downey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married (Separated)

6 (b) Name of husband or wife Eleanor Downey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	4	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sandy Downey
13. Birthplace Virginia

MOTHER
14. Maiden Name Mariah Overbay
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18th (month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location Arbutus Md

18 (a) Funeral director Elroy O'Wilson
(b) Address 1600 Washington Blvd

19 (a) (Date rec'd by registrar) SEP 17 1945 (b) Huntington Hill Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1945 to Sept 14, 1945 and that I last saw h. im alive on Sept. 14, 1945

Immediate cause of death Bronchopneumonia and cardiac failure — Duration

Due to Syphilitic heart disease arteriosclerotic

Due to Unofficinum

Other Conditions Pyuria, auricular fibrillation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address [illegible] Date signed 7/11/46

G32446

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 58E

Registered No. G32446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 Greenwillow st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 632 Greenwillow st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Zelma Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years 23 | Months | Days | If less than one day hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jacob Alexander Clark
13. Birthplace N. Y.

MOTHER 14. Maiden Name Helena Clark
15. Birthplace N. J.

16 (a) Informant Helena Clark
(b) Address 632 Greenwillow st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brandt Ave

19 (a) (Date received by Registrar) (b) Huntington Woods, Md Registrar
SEP 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14/45 19 , at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to 9/14 1945, and that I last saw her alive on 9/14 19 45

Immediate cause of death Cardiac failure — Duration 4 hrs.
Due to Rheumatic fever — 3 yrs.
Due to Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Louise Young
Address 1100 Druid Hill Ave Date signed 9/14/45

VS 190

X

G32447

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32447
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 N Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) (1) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 S. Carlson St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Herman E. Shanken

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine E. Shanken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1892

8. AGE: Years	Months	Days	If less than one day
53	0	17	hr. min.

9. Birthplace Balto Maryland
(Town, county, and State)

10. Usual Occupation ~~Ship~~ Ship Fitter

11. Industry or business Bethelem Fairfield

FATHER
12. Name August S Shanken
13. Birthplace Balto Md

MOTHER
14. Maiden Name Catherine Saduskey
15. Birthplace Unknown

16 (a) Informant Catherine E. Shanken
(b) Address 628 S. Carlson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director F. O. Kippert & Son
(b) Address 5411 Eastern Ave

19 (a) SEP 17 1945 (b) Registrar Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945, at 1124 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 14 1945, and that I last saw h/a alive on Sept 14 1945.

	Duration
Immediate cause of death: terminal toxemia	
Due to Meningococcic Pneumonitis	
Due to Pneumonia following U.R.I.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert L. Caines M. D.
Address Franklin Square Hosp. Date signed 9/14/45

VS 150

G32448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 A

Registered No. G32448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 E. Biddle St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2416 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Holland Brenner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Chas. Henry Brenner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-5-1891

8. AGE: Years	Months	Days	If less than one day
53	11	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Emily Holland
15. Birthplace Va.

16 (a) Informant Dorothy E. Devrina
(b) Address 2416 E. Biddle St

17 (a) 9-18-45 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Moreland Mem
Location Taylor Ave.

18 (a) Funeral director John E. Miller Inc
(b) Address 2418 E. Oliver St

19 (a) SEP 17 1945 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1945, at 5:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to Sept 15, 1945 that I last saw her alive on Sept 14 1945

Immediate cause of death	Duration
Coronary Occlusion	4 days
Due to Coronary Artery Disease	?
Due to Essential Hypertension	8 yrs.
Other Conditions Carcinoma of Cervix	2 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Mackin M.D.
Address Date signed 9/17/45

VS 190

G32449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G32449

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Sarahann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Sarahann (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Rollins

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1862

8. AGE: Years	Months	Days	If less than one day
83	6	10	hr. min.

9. Birthplace Prince Frederick, Md. (Town, county, and state)
10. Usual Occupation Old Age Pensionier
11. Industry or business

FATHER
12. Name Robert Rollins
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Old Age Pension Records
(b) Address 327 St. Paul Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) Date received SEP 17 1945 (b) Huntington Nutwood, Md. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14/45 19 , at 2PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-1945 to 9-14-1945.
and that I last saw h. alive on 9-13 1945.

Immediate cause of death: Chronic valvular disease of heart — Duration: 3 year
Due to
Due to
Other Conditions Arteriosclerosis — Duration: over 3 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. L. Camper M. D.
Address 639 N. Carey St Date signed 9-15-45

X

G32450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G32450

Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 Carrollton Ave
(c) Hospital or institution:

18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

3 (a) FULL NAME Robert Forest

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	Infant.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/45

8. AGE: Years	Months	Days	If less than one day
—	—	6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Marshall Forest
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Frances Williams
15. Birthplace Balto. Md.

16 (a) Informant Frances Forest (mother)
(b) Address 511 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto. Md.

18 (a) Funeral director Chas. H. Hooper
(b) Address 512 N. Carrollton Ave.

19 SEP 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Examination thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Sept. 16 1945

VS 151

G32451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G32451
Registered No.

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Jefferson st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Jefferson st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY PRETTyman (PRETTyMAN)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20 1877

8. AGE: Years	Months	Days	If less than one day
67	9	23	hr. min.

9. Birthplace Howard County Md (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name James Hackett
13. Birthplace Howard Co Md

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace Howard Co Md

16 (a) Informant John Tyler (Son)
(b) Address 2329 N Gilmor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively
(b) Address 4199 Mount st

19 (a) SEP 17 1945 (Date rec'd by Registrar) (b) Registrar

VS 3

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 19 45 at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 1945 to Sept. 13 1945, and that I last saw h alive on Sept. 11, 1945.

Immediate cause of death Cardio Renal Sclerosis — Duration 1 yr.
Due to
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Adams, M. D.
Address 312 E 23rd St. Date signed 9-15-45

4 J 32452 G32452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48A

Registered No. G32452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1936 E. Eager St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olive L. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alpheus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1894

8. AGE: Years 50 | Months 11 | Days 17 | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Borden
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Frances Fitzgerald
15. Birthplace Va

16 (a) Informant Alpheus Anderson
(b) Address 1936 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert Ellyson
(b) Address 1129 N. Caroline St.

19 (a) SEP 17 1945 (Date received by registrar) (b) Registrar

Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1945, at 12 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1944 to 9/15 1945, and that I last saw her alive on 9/14 1945.

Immediate cause of death: Carcinomatosis — Duration: 1 yr

Due to Carcinoma of cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature X Rayner Browne

Address 1700 E. Monument St Date signed 9/17 M.D.

X Rayner Browne

G32453 J

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 A

G32453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 S Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Lawson

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-03-4853

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Blanch

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 191

8. AGE: Years 54 Months 5 Days 17 If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Jessie Lawson
13. Birthplace North Carolina

MOTHER 14. Maiden Name Mary Harris
15. Birthplace North Carolina

16 (a) Informant Blanch Lawson
(b) Address 1020 S Sharp Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaiah D Brumbaugh
(b) Address 108 W Montgomery Street Huntingtown Williamsport, Md

19 (a) SEP 17 1945 (Date received by Registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 14 1945, and that I last saw him alive on Sept 14 1945

Immediate cause of death: Bronchopneumonia — Duration 3 days
Due to: Influenza — 7 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 101 S. Sharp St Date signed 9/17/45

Keep this item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G32454 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4334 Sheldon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4334 Sheldon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME -Otto Carl Reith- Otto Reith

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-9221

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma M. Reith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1899

8. AGE: Years	Months	Days	If less than one day
45	8	15	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Vilma Bakery

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Emma M. Reith
(b) Address 4334 Sheldon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/ /45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) 9-17-45 (Date received by registrar) (b) Thomas J. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1945, at 10:21 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute
Congestive heart failure, acute
pulmonary congestion
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Rene L. Sneltzer M.D.
Medical Examiner.
Date signed 9-17-45

VS 151

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied. The

G32455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G32455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 W 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 W 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob H. Sellers.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-1164

4. Sex	Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mamie P. Sellers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Carpenter.
11. Industry or business

FATHER
12. Name Samuel Sellers.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Caroline Hagle.
15. Birthplace Maryland

16 (a) Informant Mamie P. Sellers.
(b) Address 805 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Carroll Co., Md.

18 (a) Funeral director Alexander F. Donovan
(b) Address 3615-17 Eastern.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 17 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1945 at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 19.... to Sept 15 1945.
and that I last saw h.... alive on Sept 9 19 14-41

Immediate cause of death Myocardial infarction

Due to Arteriosclerosis coronary

Due to carcinoma of the prostate with bone metastasis

Other Conditions Prostatectomy O.H.K.
(Include pregnancy within 3 months of death)

Date of operation Aug (45)

Major findings of operation:

of autopsy: —

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 3429 Eastern Ave Date signed Sept 17-45

G32456

CHK-96055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

X G32456
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ann Robertson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1943

8. AGE: Years	Months	Days	If less than one day
2	6	24	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Robertson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mabel Kenny
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18-1945 (month) (day) (year)
(c) Cemetery or crematory Mount Chapel Cem.
Location Wanfield-Sabury, Md.

18 (a) Funeral director H. Bantard & Sons
(b) Address Westminster Md.

19 (a) SEP 17 1945 (Date received by registrar) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 15 1945, at 6:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1945 to Sept. 15 1945, and that I last saw h alive on Sept. 15 1945.

Immediate cause of death Respiratory failure — Duration

Due to Diarrhea

Due to

Other Conditions Diabetes Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Morrison, Jr. M. D.
Address City Hospital Date signed 9/15/45

120.a

106b

G32457 HEALTH DEPARTMENT—CITY OF BALTIMORE G32457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2001 Harlem Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2001 Harlem Ave ST., 16 WARD)

2-FULL NAME Mary Hofstetter

(a) RESIDENCE No. 2001 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 6 1863

7 AGE: Years 82 Months 8 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Constance Penz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Margaret Hofstetter (Address) 2001 Harlem Ave

15 Filed SEP 17 1945, 19 — Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 15th 1945

17 I HEREBY CERTIFY, That I attended deceased from August 21st, 19 45, to Sept 15th, 1945, that I last saw her alive on Sept 14th, 1945, and that death occurred, on the date stated above, at 12-55 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac asthenia and dilatation

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Edema Bronchitis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H. A. Hampson M.D., M. D.

Sept 15, 1945 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: 9/18 1945

20 UNDERTAKER: George A Finley — ADDRESS: Fulton & Fayette

30 B 8 Med Exam Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G32458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Raspeburg Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Winston Ave near Trumpmill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Charles Johnson
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) 11-27-1907

8. AGE: Years	Months	Days	If less than one day
37	9	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Andrew Amos
13. Birthplace Virginia

MOTHER
14. Maiden Name Eklan Oliver
15. Birthplace Virginia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19 1945 (month) (day) (year)
(c) Cemetery or crematory Lutty Hill
Location Reisterstown Md.

18 (a) Funeral director Robert L. Cowan
(b) Address 604 W. Carlton St. Huntington Williams, Mgr.

19 (a) SEP 17 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1945, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1945, to 9-15 1945, and that I last saw h[illegible] alive on 9-15 1945

Immediate cause of death Massive 2nd & 3rd Burns. Tetanus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 53-09
(b) Date of occurrence Aug 26 at 7:00 P M
(c) Where did injury occur? Raspeburg (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Burn Struck match to light stove & clothing caught fire from

23. Signature [illegible] M.D.
Address The Johns Hopkins Hosp Date signed 9-15-45

Approved, Robert Lee Frater M.D.

VS 150

G32459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G32459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner and Dukeland Sts

(c) Hospital or institution:

West Baltimore Gen'l Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore Md

(If outside city or town limits, write RURAL)

(d) Street No. 65 S. Harrison Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME

Mrs. Catherine Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Thomas Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Thomas Thomas

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Hospital Records

(b) Address

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 9 17 45 (month) (day) (year)

(c) Cemetery or crematory

Location Taylor Penna.

18 (a) Funeral director Philip Herwig Sons

(b) Address 2524 Orleans St

19 (a) SEP 17 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1945, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1945 to 9-17 1945 and that I last saw her alive on 9-17 1945.

Immediate cause of death Uremia — Duration

Due to Hypertensive Cardiovascular Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address West Baltimore General Hosp Signed 9-17-45

G32460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 White Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4402 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E Sauer

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Jan 10 1867

8. AGE: Years 78 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Ronspies
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Elizabeth Schultz
(b) Address 4404 White Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1217 E Fayette St

SEP 18 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-12 1945 to 9-15 1945 and that I last saw her alive on 9-15 1945

Immediate cause of death Cerebral Arteriosclerosis — Duration 3 yr

Due to

Due to Myocardial Degeneration — 2 weeks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Nolte M. D.
Address 1500 W Baltimore Date signed 9/17/45

VS 180

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32461

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.,
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mo3da
(e) Length of stay in Baltimore (yrs., mos., or days) 3mo3da

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4259 S. Kilpatrick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ALBERT CAPALLA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1884

8. AGE: Years	Months	Days	If less than one day
61	4	6	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business

FATHER
12. Name Matt Capalla
13. Birthplace Poland

MOTHER
14. Maiden Name Alice
15. Birthplace Poland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago

18 (a) Funeral director A. Ray Oder
(b) Address 4644 York Rd
Herrington Williams MD

19 SEP 18 1945 (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1945 at 1:10a.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15, 1945 to Sept. 16, 1945 and that I last saw him alive on Sept. 16, 1945

Immediate cause of death	Duration
Metastatic carcinoma (primary rectum) involving stomach, transverse colon, pancreas, liver abd. lymphglands and peritoneum	Unk.
Due to	
Due to	
Other Conditions Emphesema, pulmonary	Unk.

(Include pregnancy within 3 months of death)

Date of operation 7/12/45

Major findings of operation: Exploratory laparotomy

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emma T. Gledhill M. D.
Address US Marine Hospital Baltimore, Md. Date signed 9/17/45

VS 150

X

G32462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93E

G32462
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry D. Kotlicke
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	widowed

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
91			hr. min.

9. Birthplace Poland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Haskel
13. Birthplace Poland

MOTHER
14. Maiden Name Ida
15. Birthplace Poland

16 (a) Informant Mrs Bertha Smith
(b) Address 2202 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philg Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E. Balto St

19 SEP 18 1945 (b) Huntington Woods, Md. Registrar
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 1945, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 16 1945, and that I last saw h[illegible] alive on 9/16 1945.

Immediate cause of death	Duration
acute cardiac dilatation	
Due to	
Due to Chronic myocardial failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. C Feldman
Address 1446 E Balto Date signed 9/17/45

X

G32463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98

G32463 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Raynier
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4308 Pimlico Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel B. Gindler

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-4827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	White	Married

6 (b) Name of husband of (wife) Rhea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Fagg Zelda
15. Birthplace Russia

16 (a) Informant Rhea Hindin
(b) Address 4308 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) SEP 18 1945 (Date received by registrar) (b) Registrar
Hunting for Williams, M.D.

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 16 1945 and that I last saw him alive on Sept 16 1945 at 8:45 A.M.

Immediate cause of death	Duration
Respiratory failure.	
Due to Toxemia	
Due to Bilateral Gangrene of legs.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert C. Wooden M. D.
Address W.B.H.C. Date signed 9-16-45

X

G32464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822-S. Hanover (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Lee Love

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-30-1929

8. AGE: Years	Months	Days	If less than one day
15			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Sidney Love
13. Birthplace Va

MOTHER — 14. Maiden Name Marion Gresham
15. Birthplace Virginia

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A. Hayes
(b) Address 1412 W. Fell St

SEP 18 1945 (Date received by Registrar) (b) Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1945 at 6 55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-9-1945 to 9-16-1945 and that I last saw her alive on 9-16-1945

Immediate cause of death: Bronchial pneumonia, Tuberculosis Pulmonitis — Duration

Due to Tuberculosis

Due to

Other Conditions Intestinal abscess fistula;
(Include pregnancy within 3 months of death)

Date of operation April 18, 1945

Major findings of operation: Salpingitis tuberculous, Peritonitis, TB, plastic

of autopsy: not obtained

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E. Davis M.D. M. D.
Address John Hopkins Hosp Date signed 9-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G32465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 St. Mary St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 St. Mary Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Walter Topman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9, 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Topman
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Calvert Co., Md.

16 (a) Informant Miss Hattie Topman
(b) Address 438 St. Mary St.

17 (a) Burial (b) Date thereof 9-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) SEP 18 1945 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16, 1945 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/45, 19..., and that I last saw h[illegible] alive on 9/16/45

	Duration
Immediate cause of death [illegible]	
Due to [illegible]	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9/16/45

VS 150

Huntington Williams, MD

G32466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G32466

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 S. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beamie Hack

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1900

8. AGE: Years	Months	Days	If less than one day
45	6	12	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Charles Williams
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Hamlett
15. Birthplace Baltimore Md

16 (a) Informant Clarence Payne
(b) Address 642 Perkins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 04 1945 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location Baltimore County Maryland

18 (a) Funeral director Joseph A. Libely
(b) Address 409 North Mount Street

SEP 18 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16- 1945, at 9 45 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 9-17-45

G32467

AB-38671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1372

G32467

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs-9mos-14days

(e) Length of stay in Baltimore (yrs., mos., or days) 51yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1605 W. Pratt St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Timothy Angland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18- 1873

8. AGE: Years	Months	Days	If less than one day
72	6	27	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name Maurice Angland

13. Birthplace Ireland

MOTHER

14. Maiden Name Ellen Callahan

15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director MARTIN FAHEY & SONS

(b) Address 1827 N. North Ave

19 (a) Filed SEP 19 1945 (b) Registrar Huntington Woods, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-15- 1945 at 9.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26-37 1937 to 9-15- 1945, and that I last saw him alive on 9-15 1945

Immediate cause of death Bronchopneumonia — Duration: 3 days

Due to

Due to

Other Conditions Pyelonephritis

(Include pregnancy within 3 months of death)

Date of operation 8-20-45

Major findings of operation: D.P.H.E. urinary retention

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas J. O'Neill M. D.

Address Balto City Hospitals Date signed 9-17-45

G32468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940

Registered No. G32468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 Edgevale Rd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Edgevale Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Riegel Swinehart

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dr. E. W. Swinehart
6 (c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): August 12 1879

8. AGE: Years 66 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Sol. D. Riegel
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Mary Rush
15. Birthplace: Ohio

16 (a) Informant: Dr. E. W. Swinehart (husband)
(b) Address: 103 Edgevale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 45 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore

18 (a) Funeral director: Stewart Memorial Co.
(b) Address: 108 W North Ave.

19 (a) Filed SEP 19 1945 (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on Sept. 16 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 2 hours
Due to: Coronary Arterio Sclerosis — 5 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature: W. Gibson Porter M. D.
Address: 4822 Rolandale Date signed: 9/17/45

VS 190

G32469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 A

G32469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 725 Baker St

(c) Hospital or institution: 154

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 725 Baker St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Elenora Sallee SALLEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	married

6 (b) Name of husband or wife James Sallee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name Frank Smothers

13. Birthplace md

MOTHER

14. Maiden Name Annie Whittington

15. Birthplace md

16 (a) Informant James Sallee

(b) Address 725 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location md

18 (a) Funeral director George E. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) SEP 18 1945 Huntington Williamsport Md

(Date received by Local Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 19 45, at 11 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5-45, to 9/16-45, and that I last saw h[illegible] alive on 9/16-45.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ben Roberts M. D.

Address [illegible] Date signed 9/17/45

X

632470

JL - 95588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137A

Registered No. 632470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1067 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Henrietta (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1881

8. AGE: Years	Months	Days	If less than one day
64	6	20	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Watkins
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Govans Md

18 (a) Funeral director Robert E. Williams
(b) Address 13-15 McElderry St.

19 (a) SEP 18 1945 (Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1945 at 7:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20, 1945 to Sept. 15 1945 and that I last saw h. alive on Sept. 15 1945

Immediate cause of death	Duration
Uremia	1 wk
Due to pyelonephritis	2 wks
Due to Benign hyperplasia of prostate	1 yrs
Other Conditions Urinary retention	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Divilli M. D.
Address Balto. City Hosps Date signed 9-17-45

VS 150

G32471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G32471

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ned Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Frank Hill

13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah ?

15. Birthplace Virginia

16 (a) Informant Abraham Hill

(b) Address 1026 Sterling St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. County, Md.

18 (a) Funeral director Joseph E. Lyles

(b) Address 1314 N. Central Ave.

SEP 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1945, at 2:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Fraker M.D.
Medical Examiner

Date signed 9-18-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G32472 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4139 Eierman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4139 Eierman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George N. St. Ours
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28-1896

8. AGE: Years	Months	Days	If less than one day
49	5	20	hr. min.

9. Birthplace Minnesota (Town, county and state)
10. Usual Occupation Engr Designer
11. Industry or business Glenn L Martin

FATHER
12. Name Joseph St. Ours
13. Birthplace ✓

MOTHER
14. Maiden Name Mary ✓
15. Birthplace ✓

16 (a) Informant Mrs. Anna E. St. Ours
(b) Address 4139 Eierman Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Leonard J. Rupp
(b) Address 5305 Harford Rd.
SEP 18 1945 (Date received by registrar) (b) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 - 1945, at M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1945, to 19, and that I last saw h/M alive on 19.

Immediate cause of death	Duration
Coronary occlusion	
Due to arterio-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Preston A. Anderson M. D.
Address 3661 Shannon Drive Date signed 9/18/45

X

VS 150

G32473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G32473 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Morris Heagy Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Anna Theresa.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1866

8. AGE: Years	Months	Days	If less than one day
79	3	1	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William H. Heagy
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia C. Harris
15. Birthplace Md.

16 (a) Informant Mr. Samuel M. Heagy
(b) Address 3211 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1945 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1945 to Sept 16 1945 and that I last saw h[illegible] alive on Sept 16 1945

Immediate cause of death	Duration
Chronic nephritis	2 yrs.
Due to Arterio sclerosis	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dewees Mooren M. D.
Address 3109 Belair Rd Date signed 9-17-45

VS 150

X

(1) Transcript
1 Permit G32474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X G32474
93D
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTIMORE
(c) City or town Baltimore Highlandtown
(If outside city or town limits, write TOWNSHIP and COUNTY)
(d) Street No. 610 S Liberty Court
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME John N. Gehring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Annie J.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	24	..... hr. ..... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adam Gehring
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Pickle
15. Birthplace Germany

16 (a) Informant James H. Thompson
(b) Address 6108 Liberty Hghts. Ave.

17 (a) Burial (b) Date thereof Sept. 1
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4301 Old Frederick Rd

18 (a) Funeral director Harry H. Suttle
(b) Address 4101 E Monument Ave

19 (a) [illegible] SEP 18 1945 Huntington Williams, M.D.
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 19 45 - at 10:40 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 19 45 - to 9/16 19 45 -
and that I last saw him alive on 9/15 - 19 45 -

Immediate cause of death	Duration
Coronary Thrombosis	15 min.
Due to Arteriosclerotic C. V. Disease	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 9/16/45

VS 2

G32475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170 C

G32475

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glen Arm
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MARGARET SCHEFFLEIN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NO

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: ANDREW SCHEFFLEIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1869

8. AGE: Years 75 | Months 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Frderiick Schneider
13. Birthplace: Germany

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Olive Weber
(b) Address: Glen Arm Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory: First Evangelical Cem.
Location: Baltimore Maryland

18 (a) Funeral director: Henry Sander & Sons. Inc.
(b) Address: North AVE & Broadway

19 (a) (Date received by registrar) SEP 18 1945 (b) Huntington Williams, M.D. Registrar

VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1945 at 4 A.M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-45 at 8 30 P. M.
(b) Where did injury occur? Monroe & Wicheln
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Passenger fell from auto.

23. Signature: Thomas J. Mudera M.D.
Medical Examiner.
Date signed 9-17-45

X

G32476 Welk

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G32476

Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Potomac Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Ruley - Welk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/16

8. AGE: Years	Months	Days	If less than one day
29 yrs	4	16	hr. min.

9. Birthplace Md. Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George C. Ruley
13. Birthplace Md Baltimore

MOTHER
14. Maiden Name Elizabeth Stern
15. Birthplace Baltimore, Md.

16 (a) Informant ~~Relatives~~ JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof 9/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

SEP 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 15 1945 and that I last saw her alive on Sept 15 1945

Immediate cause of death Coronary Occlusion
Coronary Sclerosis & Angina
& Massive Pulmonary Edema.
Due to
Contributory Conditions
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9/14/45
Major findings of operation: Increased intracranial pressure.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-10-45 at M
(c) Where did injury occur? 401 Potomac Ave, Chevy Chase
(City or town) (County) Balto. Co., Md.
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury: Fall from porch

23. Signature Louis V. Saunders M.D.
Address 5111 Belvieu Road Date signed 9/15/45
Balto. Md.
Howard J. Haslam M. D.

632477

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D

Registered No. 632477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st Street
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE EDWARD CORNWELL

3 (b) If veteran, name war: World War # I
3 (c) Social Security Account No. 217-03-5721

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna Cornwell
6 (c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Aug. 23, 1896
8. AGE: Years 49 | Months 0 | Days 22 | If less than one day ##### min.
9. Birthplace: Roedville, Virginia (Town, county, and state)
10. Usual Occupation: Chauffeur
11. Industry or business: Department Store

FATHER
12. Name: Orbin Cornwell
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Georgianne Smith
15. Birthplace: Virginia

16 (a) Informant: Records-US Marine Hospital
(b) Address: Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's Hampden
Location: Baltimore, Md

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date rec'd by registrar) SEP 18 1945 (b) Registrar Huntington Millcreek, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1945, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4, 1945 to Sept. 15, 1945 and that I last saw him alive on Sept. 15, 1945

Immediate cause of death: Carcinoma of rt. lung with metastases to pleura, rt. lung ~~###~~ and lymph glands — Duration: Unk.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: As Above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John L. Wilson
Address: US Marine Hospital, Baltimore, Md. Date signed 9/17/45

X

G32478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G32478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 S. Collins Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 S. Collins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Berthold Vogel

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-16-7853

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa H. Vogel

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept 22 1862

8. AGE: Years 82 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Quarryman

FATHER
12. Name ?
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Theresa H. Vogel
(b) Address 138 S. Collins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Bath & B. M. Valley City

18 (a) Funeral director Pratt & Stricker Sts
(b) Address

19 (a) Date received Sep 18 1945 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1945 to Sept 15 1945, and that I last saw h[illegible] alive on Sept 15 1945.

Immediate cause of death Carcinoma rectum — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant E. Board M. D.
Address Medical Arts Bldg. Date signed Sept 16 '45
Baltimore 1 - Md

G32479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

Registered No. G32479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Wildwood Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 6 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD or Rural and give town)
(d) Street No. 533 Wildwood Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah E. Murphy.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Mrs. P.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6 or 9 - 1865
8. AGE: Years 79 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lawrence Kennedy.
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Burnes.
15. Birthplace Ireland

16 (a) Informant Mrs. Thomas E. Watson
(b) Address 533 Wildwood Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20 1945 (month) (day) (year)
(c) Cemetery or crematory New South Location Old Frederick Rd.

18 (a) Funeral director Wm. A. Moran
(b) Address 3600 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1945 at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1945 to Sept 16 1945, and that I last saw h[illegible] alive on Sept 16 1945

Immediate cause of death: Cerebral Hemmorage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A. Orf M. D.
Address 537 Wildwood Pkwy Date signed 9-17-45

X

G32480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 920

G32480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 S. Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 S. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John D. Baker Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Baker

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1884

8. AGE: Years 60 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Foreman.

11. Industry or business Dyerson Chem

FATHER
12. Name John D. Baker
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Helen Haas
15. Birthplace Penn

16 (a) Informant Mrs Mary Baker
(b) Address 611 S. Port St

17 (a) Burial (b) Date thereof Sept 19 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Hr.
Location Balto Md

18 (a) Funeral director L. HECHMANN & Son
(b) Address 32 S. Broadway

(a) SEP 18 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1945 to Sept. 15, 1945 and that I last saw him alive on Sept. 13, 1945

Immediate cause of death Cerebral Hemorrhage

Due to Chronic Hypertension

Due to

Other Conditions Chronic Nephritis
Heart Disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: —

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John D. Baker M. D.
Address 611 S. Port St Date signed Sept 17 1945

VS 180

G32481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7600 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Jeannette — Haas

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Oliver Haas
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1/14/1909

8. AGE: Years	Months	Days	If less than one day
36	8	4	____ hr. ____ min.

9. Birthplace Louisiana (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Oliver Haas
(b) Address 7600 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Md.

18 (a) Funeral director Gilbert Undertaking Co.
(b) Address 1217 E. Fayette St.

SEP 19 1945

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 45 at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 19 45 to Sept 18 19 45 and that I last saw h[illegible] alive on Sept 18 19 45

Immediate cause of death Uremia — Duration 1 mo.

Due to Advanced interstitial nephritis and arteriosclerosis — 1 yr.

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature C. Milton Linthicum M. D.
Address Mercy Hospital Date signed 9/18/45

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

X G32482

Registered Number

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo. 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn (b) County
(c) City or town Groton (If outside city or town limits, write RURAL and give town)
(d) Street No. Coast Guard Training Station (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME John Lawler Lavoie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret E. Lavoie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1920

8. AGE: Years	Months	Days	If less than one day
25	6	28	hr. min.

9. Birthplace Hartford, Connecticut (Town, county, and state)
10. Usual Occupation Lieutenant, jg Coast Guard
11. Industry or business Seafaring

FATHER
12. Name Arthur Lavoie
13. Birthplace Hartford, Conn

MOTHER
14. Maiden Name Marguerite Lawler
15. Birthplace Hartford, Conn

16 (a) Informant Records - U.S. Marine Hospital
(b) Address Baltimore 11, Maryland

17 (a) Removal (Burial, cremation, or removal) (b) Date then Sept 18-1945 (month) (day) (year)
(c) Cemetery or crematory Middletown Conn
Location

18 (a) Funeral director Pratt Carr B. M. Walters
(b) Address Pratt & Strickler Sts Huntington West Virginia

19 SEP 19 1945 (b) State registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 18 1945, at 6:12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1945 to Sept 18 1945, and that I last saw him alive on Sept. 18 1945.

Immediate cause of death Hodgkins Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M. D.
Address U. S. Marine Hospital Date signed 9/18/45

VS 150

X

G32483

CWK-95845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G32483
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 5'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day-9 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Day-9 Hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 S Milton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Goldston, Baby Boy.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3-1945

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos Nelson Scott
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Rebecca Goldston
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) 9-17-45 (Burial, cremation, or removal) (b) Date thereof 9-17-45 10 A.M. (month) (day) (year)
(c) Cemetery or crematory B. C. Hosp Crematory
Location 4940 Eastern ave

18 (a) Funeral director
(b) Address

19 (a) SEP 10 1945 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1945, to Sept. 4 1945, and that I last saw him alive on Sept. 4 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intracranial Hemorrhage	
Due to Depressed Fracture	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edw T Lee
Address 7 B Ct. Date signed 9/11/45

VS 150

G32484
JL - 96038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1192

G32484
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Delano Chittum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1945

8. AGE: Years	Months	Days	If less than one day
	1	26 27	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Chittum
13. Birthplace Va.

MOTHER
14. Maiden Name Arlia Robinson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1945 (month) (day) (year)
(c) Cemetery or crematory Greenhill
Location Bypass, Vista, Va.

18 (a) Funeral director Frederick & Dale
(b) Address 1230 N. Monroe St.

SEP 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1945 5:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1945, to Sept. 18 1945, and that I last saw h 18 alive on, Sept. 18 1945.

Immediate cause of death	Duration
Diarrhea	
+ Respiratory Infection	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Halsted M.D.
Address Baltimore City Hospitals Date signed 9/18/45

VS 150

G32485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183a

G32485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2174 Carlton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2174 Carlton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elonia Fletcher Flagg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elijah Flagg

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): July 8, 1904

8. AGE: Years: 41 | Months: 2 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Howard Co Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Burgess
13. Birthplace: Howard Co Md

MOTHER
14. Maiden Name: Mary Stewart
15. Birthplace: Howard Co Md

16 (a) Informant: Elijah Flagg
(b) Address 2174 Carlton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 19, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location

18 (a) Funeral director: Mrs Kate B. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept 15 1945 and that I last saw h[illegible] alive on Sept 15 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 hour

Due to: Hypertension — 6 mo

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature: W. H. Watts
Address 515 Linwington Ave Date signed: 9/[illegible]/45

SEP 19 1945 Huntington Williams, M.D.

G32486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G32486
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 669 George
(c) Hospital or institution 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 669 George (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Thomas A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Northumberland Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Robinson.
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Robinson.
15. Birthplace Va.

16 (a) Informant Thomas A Garrett
(b) Address 669 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-'45 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 SEP 19 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by Local Reg.)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1945 at 11 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 14 1945 to Sept 17 1945.
and that I last saw h[illegible] alive on Sept 17 1945.

Immediate cause of death — Duration
Myocarditis — 8 months
Due to Influenza
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Moore
Address 75 W Franklin Date signed 9/18/45 M. D.

G32487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G32487 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Agnes Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21

8. AGE: Years	Months	Days	If less than one day
54	3	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Hughes
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Annie Hunter
15. Birthplace Howard Co. Md.

16 (a) Informant Francis Hampton
(b) Address 3129 Lee St.

17 (a) Burial (b) Date thereof 9-19-'45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

SEP 19 1945 (b)
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15- 1945, at 11,45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2- 1945, to 9-15- 1945, and that I last saw her alive on 9-14- 1945.

Immediate cause of death Cardio Renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Conyers M. D.
Address 611 N. Carolina Date signed 9-16-45

G32488

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G32488 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Madison Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Chisolm

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Burdette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1887

8. AGE: Years	Months	Days	If less than one day
57	11	6	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Cecil Chisolm
13. Birthplace S. C.

MOTHER
14. Maiden Name Leane
15. Birthplace S. C.

16 (a) Informant Burdette Chisolm
(b) Address 2301 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon Cemetery
Location Baltimore, Md.

18 (a) Funeral director Winfield G. Gaddis
(b) Address 2101 Mc Culloh St

19 (a) SEP 19 1945 (Registrar's record of receipt) Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 16 1945 at 8-A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1945 to Sep 16 1945, and that I last saw [illegible] alive on Sep 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Pulmonary Infarction	
Due to Arteriosclerotic Hypertensive Card. Vas. Dis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Rowell
Address 601 N Broadway Date signed 9/19/45 M.D.

G32489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2533 E. Monument St.,
(c) Hospital or institution:
7-W
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 E. Monument St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTON SEALANDER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Sealander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1869

8. AGE: Years	Months	Days	If less than one day
76	1	22	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Stationary engineer
11. Industry or business

FATHER
12. Name Ernest Sealander
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Beherns
15. Birthplace Germany

16 (a) Informant Henry Meil
(b) Address 2533 E. Monument St.,

17 (a) Burial (b) Date thereof 9/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1945 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Sept 17 1945 and that I last saw h[illegible] alive on Sept 15 1945.

Immediate cause of death Edema of the lungs

Duration: Couple of months

Due to Heart - insufficiency

Due to Arteriosclerosis - Myocardegeneration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Trampett M. D.
Address 11 E. Chase St. Date signed 9-18-45

G32490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32490
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State West Va. (b) County
(c) City or town Dover
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Dean Smith

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1944

8. AGE: Years	Months	Days	If less than one day
	11	4	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Denver Smith
13. Birthplace West Va.

MOTHER
14. Maiden Name Ethel Raines
15. Birthplace West Va.

16 (a) Informant Denver L Smith
(b) Address 1800 Bardon St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/19/45 (month) (day) (year)
(c) Cemetery or crematory Dover
Location Dover W. Va.

18 (a) Funeral director Thelma Coffman
(b) Address 1214 Light St.

SEP 19 1945 (Date received by local registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1945 at 11 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1945 to Sept. 18 1945 and that I last saw him alive on Sept. 18 1945

Immediate cause of death	Duration
Acute gastric dilitation	1 day
Due to Post-operative gastro-enterostomy	
Due to	
Other Conditions Pyloric stenosis and duodenal adhesions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 18, 1945
Major findings of operation: Pyloric stenosis and duodenal adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Meyerpark Spragins
Address U. M. H. Date signed 9-18-45

VS 150

Huntington for Williamson, W. Va.

G32491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G32491

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY & FAIRMOUNT AVE.
(c) Hospital or institution:
CHURCH HOME HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 N. CHARLES ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DICKEY, ELIZABETH NEAL

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 10 | 29 | 1876
8. AGE: Years 68 | Months 10 | Days 19 | If less than one day: hr. min.
9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name DICKEY, HAROLD R.
13. Birthplace MARYLAND

MOTHER
14. Maiden Name FUNK, ELIZABETH
15. Birthplace BALTIMORE

16 (a) Informant DICKEY, ELIZABETH N.
(b) Address 2710 N. CHARLES ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 19 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 18 1945 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1945 to 9/18 1945 and that I last saw her alive on 9/18 1945.

Immediate cause of death: INATIATION & INTESTINAL OBSTRUCTION — Duration
Due to GENERALIZED CARCINOMATOSIS
Due to PRIMARY CARCINOMA OF CAECUM
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9/17/45
Major findings of operations: AS ABOVE
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George B. Leech, Jr. M.D.
Address 1211 Cathedral St. Date signed 9-18-45

G32492

G32492
CEK-13540

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10- 9- 1 26
(e) Length of stay in Baltimore (yrs., mos., or days) ??

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. City Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Esslinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9-1880

8. AGE: Years	Months	Days	If less than one day
65	4	7	hr. min.

9. Birthplace Carroll County, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Esslinger
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Nichols
15. Birthplace England

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory Oella Cem.
Location Oella, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 10 1945 (b) Huntington Williams M.D. Registrar
(State rule by registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 16 1945 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1945, to Sept. 16 1945 and that I last saw h. alive on Sept. 16 1945.

Immediate cause of death: Congestive Ht. failure — Duration: 3 days

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret A. Davis M. D.
Address 4940 Eastern Ave., Date signed 9-12-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BINDING

632493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 95 63493

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSE R. KENNEALLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rita C. Kenneally
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Receiving Clerk
11. Industry or business Fry & Sons

FATHER
12. Name William R. Kenneally
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillie ?
15. Birthplace --

16 (a) Informant Mrs. Rita C. Kenneally
(b) Address 1703 Poplar Grove St.

17 (a) Burial (b) Date thereof 9/ /45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 19 1945 (b) Registered by [illegible] Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1945, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1943 to 9/15 1945; and that I last saw h-- alive on 9/15/ 1945.

Immediate cause of death: Cerebral Hemiplegia.
Due to Arteriosclerosis.
Due to Related heart.
Other Conditions

Duration
10 mnths
10 mnths.
2 yrs.
1 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Kerns
Address 1202 St Paul St Date signed 9/17/45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32494

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3334 Mondawmin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Mondawmin Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEONARD J. LENTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife M. Pearl Lentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1896

8. AGE: Years	Months	Days	If less than one day
48	8	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Poultry Business
11. Industry or business Self

FATHER
12. Name Charles Lentz
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Kreiner
15. Birthplace Maryland

16 (a) Informant Mrs. M. Pearl Lentz
(b) Address 3334 Mondawmin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 19 1945 (b) (Date rec'd by registrar)

Huntington Woodside, M. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1945, at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1945 to Sept. 17 1945 and that I last saw him alive on Sept. 17 1945

Immediate cause of death	Duration
Coronary Occlusion	5 min.
Due to	
Coronary vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hall S. Talbott M. D.
Address 2220 Garrison Blvd. Date signed 9/18/46

AdCo. 5-31 2500

HEALTH DEPARTMENT—CITY OF BALTIMORE

G32495

CERTIFICATE OF DEATH

83A

G32495

1. PLACE OF DEATH Gate Pine Crest

CITY OF BALTIMORE: (No. 600 S Chapel Gate Lane St., 25-1 Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs. ....mos. 8 ds. How long in U.S. If of foreign birth? ....yrs. ....mos. ....ds.

2. FULL NAME Eugene Towe

(a) Residence: No. ..... St., ... Ward. .....
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb. 6 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	7	12 13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Balto Co.

FATHER

13. NAME P Frank Towe

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Helen M Cune

16. BIRTHPLACE (city or town) (State or country) Carroll Co

17. INFORMANT Miss S. King

(Address) Owings Mills

18. BURIAL, CREMATION, OR REMOVAL

Place All Saints Date Sept. 20 1945

19. UNDERTAKER J. F. Elsie & Sons

(Address) Reisterstown Md.

20. FILED SEP 19 1945 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/19, 1945

22. I HEREBY CERTIFY, That I attended deceased from 9/11, 1945, to 9/19, 1945

I last saw h. alive on 9/19, 1945 death is said to have occurred on the date stated above, at 2.30A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Left Cerebral Hemorrhage	4 days
Other contributory causes of importance:	
Arteriosclerosis	?
Bilateral Inguinal Hernia	?

Name of operation ..... Date of .....

What test confirmed diagnosis? Findings Were an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) Damian P. Alagia M. D.

(Address) 332 N. Fremont Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STEM

632496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

632496 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6001 Falls Road

(c) Hospital or institution:

27

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 6001 Falls Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary A. Stem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jesse F. Stem

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1875

8. AGE: Years 70 Months 0 Days 20 If less than one day hr. min.

9. Birthplace Carroll Co Md

(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Joseph Arndorff

13. Birthplace Unknown

MOTHER 14. Maiden Name Maria Buckley

15. Birthplace Unknown

16 (a) Informant Jesse F. Stem

(b) Address 6001 Falls Road

17 (a) Burial (b) Date thereof Sept 2/1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Johns

Location Westminster Md

18 (a) Funeral director Harry T. Hammond

(b) Address 4204 Edgewood Ave

19 (a) (b)

(Signature and address of person acting as undertaker)

SEP 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 1942 to 9-17 1945 and that I last saw h er alive on 9-17 1945

Immediate cause of death Coronary Thrombosis

Duration 1 wk

Due to Arteriosclerotic CVD & Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Laurence J. Simonds M. D.

Address 3711 Falls Rd Date signed 9-17 1945

VS 150

632497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1612

632497 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John Steed & Lafayette Ave.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1/2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 3429 Shannon Dr
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. John Steed & Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Lee Wilke

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 17-1945
8. AGE: Years | Months | Days | If less than one day: 12 hr. 12 min.
9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick William Wilke
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Violet Leona Hoffbeck
15. Birthplace Baltimore Md.

16 (a) Informant Husband
(b) Address 3429 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem. Co.
Location Balto. Md.

18 (a) Funeral director Leonard Flamm
(b) Address 5300 Harford Rd

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 19 1945

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18th 1945; at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17th 1945, to Sept. 18th 1945, and that I last saw her alive on Sept. 18th 1945.

Immediate cause of death Respiratory failure — Duration: 12 hrs 12"

Due to Atelectasis — Duration: 12 hrs 12"

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-17-45 Character

Major findings of operation:

of autopsy: None obtained

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address Women's Hospital Date signed 9/18/45
Baltimore Md

G32498

AB-85591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113B

G32498

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-8mos-14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Katherine White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14- 1908

8. AGE: Years	Months	Days	If less than one day
37	6	3	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William L. Dailey
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Dailey
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 21-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Flannigan
(b) Address 1426 Light St.

19 (a) (b) Huntington, Maryland

SEP 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1945, at 12.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23- 1943, to 9-17 1945, and that I last saw h er alive on 9-17- 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Eberhard Jr. M. D.
Address Balto. City Hosp. Date signed 9/17/45

G32499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32499 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 Thames Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Thames Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Otto Rojek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Katherine Rojek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name George Rojek
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine Broda
15. Birthplace Poland

16 (a) Informant Katherine Rojek Wife
(b) Address 1811 Thames Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 20 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester street

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 19 1945 Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1945 at 9 PM

21. I certify that I took charge of the remains described above, held an D & A thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to arteriosclerosis CVD

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph A. Sheehan M.D. Medical Examiner.
Date signed 9/16/45

X SHEEHAN

G32500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N. Regiestown
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Regiestown
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Lee Hairston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Odel Hairston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1911

8. AGE: Years 33 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Lee County South Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Tiller
13. Birthplace S. C.

MOTHER
14. Maiden Name Angenine Roger
15. Birthplace S.C.

16 (a) Informant William Thomas
(b) Address 1637 Millington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 21-40 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location

18 (a) Funeral director Elroy O. Oglesby
(b) Address 1009 Bentley ave

19 (a) SEP 19 1940 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17, 1940 at 8:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1940 to Sept 16 1940 and that I last saw h[illegible] alive on Sept 15 1940

Immediate cause of death Tuberculosis — Disseminated

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Tuberculous Peritonitis.

of autopsy: None.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph R. Stevenson M. D.
Address Hopkins Hospital Date signed 9-17-40

VS 180

X

G32501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G32501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full name of street address, city, etc. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Jefferson Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Barber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Grace Barber

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 4 - 1899

8. AGE: Years 46 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Columbia S.C. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Alexander Barber
13. Birthplace S.C.

MOTHER
14. Maiden Name Sheilds ?
15. Birthplace S.C.

16 (a) Informant Grace Barber
(b) Address 1201 Jefferson Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 21-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Cleon O. Wilson
(b) Address 1005 Brantley ave

19 (a) SEP 19 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1945 at 11 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gunshot wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17-45 at 10 50 A.M.
(b) Where did injury occur? Apt. B "2" 1201 Jefferson Ct.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm (Revolver)

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-17-45

G32502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1863

Registered No. G32502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in Hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Mc Cabe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. May

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 234-69-9777

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of ~~husband~~ or wife: Dorendia May

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 14. 1887

8. AGE: Years: 58 | Months: 1 | Days: 14 | If less than one day: hr. min.

9. Birthplace: W. Va. (town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business: Bethlehem Steel Corp

FATHER
12. Name: Alpheus May
13. Birthplace: W. Va.

MOTHER
14. Maiden Name: Maude Norris
15. Birthplace: W. Va.

16 (a) Informant: Royal W. May
(b) Address: 621 Mc Cabe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-21-45 (month) (day) (year)
(c) Cemetery or crematory: Greenlawn
Location: Clarksburg, W. Va.

18 (a) Funeral director: H. Howard Strong
(b) Address: 3707 W. North Ave.

SEP 19 1945 (Date received by Local Registrar) (b) Huntington, W. Va.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1945; at 9:10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 7, 1945 (24-2) A.M.
(b) Where did injury occur? Bethlehem Shipyard
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? No
(d) Means of injury: Hatch cover fell on him

23. Signature: [illegible] M.D. Medical Examiner.
Date signed 9-18-45

G32503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G32503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth B. H. Stinson

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 27 1860

8. AGE: Years 85 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Carlisle Pa
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew J Wilcox
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane Ellen Hoffer
15. Birthplace Carlisle Pa

16 (a) Informant Elizabeth Stinson
(b) Address 1708 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Tilghman & Son
(b) Address 1217 Pont St.

19 (Date rec'd by registrar) SEP 19 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945, at 8:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Sept 18 1945, and that I last saw h[er] alive on Sept. 18 1945.

Immediate cause of death: Carcinoma of the Bladder — Duration: 3 years.
Due to
Due to
Other Conditions: Cystitis - Sclerosis generalized — Duration: Years.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry L. Hanson M. D.
Address 1306 E. Preston St. Date signed 9/19/45

VS 150

632504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 632504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ada R. Rosenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16 1870

8. AGE: Years	Months	Days	If less than one day
75	1	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired hospital
11. Industry or business Dept.

FATHER
12. Name John J. Rosenthal
13. Birthplace Conn.

MOTHER
14. Maiden Name Sophia Weisenbach
15. Birthplace Balto. Md.

16 (a) Informant Mr. Louis Rosenthal
(b) Address Seville Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Burial Association of Balto
(b) Address 1902 Eutaw Place

19 SEP 19 1945 (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1941, to Sept 17 1945, and that I last saw h[illegible] alive on Sept 17 1945.

Immediate cause of death: Congestive failure — Duration

Due to: Hypertensive arterio sclerotic cardiovascular disease

Due to:

Other Conditions: pneumonia; diabetes mellitus; left hemiplegia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Schaeffer M. D.
Address Sinai Hospital Date signed Sept 17, '45

VS 150

93D

632505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

632505

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2246 E Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Konstanty (Gus) Goszkowski

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Mechanic
11. Industry or business

FATHER
12. Name Josef Goszkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Teofila
15. Birthplace Poland

16 (a) Informant Stanley Goszkowski
(b) Address 13 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 20/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1950 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
SEP 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1945 at 2 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Internal hemorrhage due to
ruptured liver & fractured ribs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17-45 at 1 15 A.M.
(b) Where did injury occur? Eastern Ave. & Ann St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Thomas J. Mirabeau M.D. Medical Examiner.
Date signed 9-17-45

G32506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G32506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS
(c) Hospital or institution: UNION MEMORIAL HOSP. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 FOREST PARK AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MR. CHARLES EARLE HOLLYDAY SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MRS. MARGARET HOLLYDAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-7-1871

8. AGE: Years	Months	Days	If less than one day
74	1	11	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business

FATHER
12. Name MR. RICHARD HOLLYDAY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name [redacted] ELIZABETH EARLE
15. Birthplace MARYLAND

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month, day, year)
(c) Cemetery or crematory Springhill Cem.
Location Springhill Md.

18 (a) Funeral director Mamie Zeffer
(b) Address 1600 W. North Ave.

19 (a) SEP 19 1945 (Signature of registrar) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 18 1945 at 6 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 15 1945 to SEPT 18 1945 and that I last saw him alive on SEPT 18 1945.

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	
Due to CORONARY OCCLUSION	
Due to ARTERIOSCLERATIC CORONARY ARTERY DIS.	
Other Conditions Arteriosclerosis, General	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Good III
Address Union Mem. Hosp. Date signed M. 9/18/45 D.

G32507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

G32507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Parkman
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Edgehill Ave (If rural give location)
(e) Citizen of foreign country? England (Yes or No)
If yes, name country

3 (a) FULL NAME Milton C. Shildt

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-6298

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth A. Shildt

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 7, 1873

8. AGE: Years 72 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Pennsylvania. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Samuel Shildt
13. Birthplace Pennsylvania.

MOTHER: 14. Maiden Name Sarah Brown
15. Birthplace maryland.

16 (a) Informant Elizabeth A. Shildt
(b) Address 4208 Edgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22/45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge
Location Wash. Blvd.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/45, 1945, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1945, to 9/17 1945, and that I last saw him alive on 9/9 1945.

Immediate cause of death: cerebro Vascular Hemorrhage — Duration

Due to arteriosclerotic cardio vascular disease

Due to

Other Conditions Abdominal aneurism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Lowe M. D.
Address Franklin Square Hosp. Date signed 9/19/45

93D

G32508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G32508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Berry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Berry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise C. Meyls.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John H. Meyls.
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec 14. 1890

8. AGE: Years	Months	Days	If less than one day
about 54?	9	3	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Machinist Dept
11. Industry or business Brass Foundry

FATHER
12. Name Eugene Henschel
13. Birthplace Maryland.

MOTHER
14. Maiden Name Katherine?
15. Birthplace Unknown

16 (a) Informant John H. Meyls.
(b) Address 720 Berry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 19 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1945, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1945 to Sept 17 1945; and that I last saw h[illegible] alive on Sept 16 1945.

Immediate cause of death	Duration
Hemorrhage	1 day
Due to Myocardial degeneration	
Due to Cardio Renal Vascular disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J H Wilson M. D.
Address 617 W. 40th St Date signed 9/19/45

3619 G32509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1331 G32509 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel Co
(c) City or town Pasadena Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-1930

8. AGE: Years	Months	Days	If less than one day
14	10	19	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nicholas Hartman
13. Birthplace ?

MOTHER
14. Maiden Name Anna ?
15. Birthplace ,

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Georgetown Site by Baltimore

18 (a) Funeral director J. J. Haley Sons
(b) Address 3128 Light St.

19 (a) SEP 19 1945 (b) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1945 at 7 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1945 to 9-17 1945 and that I last saw him alive on 9-17 1945

Immediate cause of death Pleural effusion, bilateral

Due to uremia, hypoproteinemia

Due to congenital hypoplastic kidney, Hydronephrosis

Other Conditions urinary tract infection aerobacter

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: general anasarca

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Date signed 9/19/45

G32510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Light St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Gilchriest

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) May 28, 1870

8. AGE: Years	Months	Days	If less than one day
65	3	20	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business —

FATHER 12. Name James Gilchriest
13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Hutchinson
15. Birthplace Maryland

16 (a) Informant Mrs Mabel Gilchriest
(b) Address 907 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Ave

18 (a) Funeral director John F. Denny Inc
(b) Address 745 Light St.

19 (a) SEP 20 1945 (Date received by local registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18 1945 at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Sept 18 1945 and that I last saw him alive on Sept 17 1945.

Immediate cause of death	Duration
Cerebral Apoplexy.	
Due to	
Due to	
Other Conditions Arteriosclerosis hypertension & myocarditis	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Gilchriest
Address 1337 S. Clinton St. Date signed 9/19/45

VS 150

G32511 — 108 — Registered Number G32511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT ST.
(c) Hospital or institution: SO. BALTO. GEN. HOSP. 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 BATTERY AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George Sands
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wh.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-44

8. AGE: Years	Months	Days	If less than one day
	8 9	23	hr. min.

9. Birthplace BALTO., MD (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name JAMES SANDS
13. Birthplace BALTO., MD.

MOTHER
14. Maiden Name OLIVE THOMPSON
15. Birthplace MARYLAND

16 (a) Informant OLIVE SANDS
(b) Address 1128 BATTERY AVE
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Annapolis Blvd.
18 (a) Funeral director John F. Fleming Dec.
(b) Address 718 Light St.
SEP 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 18, 1945 at 10:15 P M
21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 16, 1945 to SEPT. 18, 1945 and that I last saw him alive on SEPT. 18, 1945

Immediate cause of death	Duration
Pneumonia - Lobar - Rt. Lower Lobe	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. Ehrlich M. D.
Address 1213 Light St Date signed 9-19-45

VS 150

G32512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a X

Registered No. G32512

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D. S A.
(b) Street address 718 Newington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Boston (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Cumberland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Solomon Sommers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Salesman

FATHER
12. Name Unkown
13. Birthplace Unkown

MOTHER
14. Maiden Name Unkown
15. Birthplace Unkown

16 (a) Informant Goldstein
(b) Address 718 Newington Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Sept, 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Boston Mass.
Location Boston Mass.

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 Wash North ave

19 (a) SEP 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1945 at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Primary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature F. P. Calabresi M.D. Medical Examiner.
Date signed 9/19/45

VS 151

G32513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. G32513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Powhattan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Powhattan Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie L. Behrend

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Abe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 77 | Months | Days | If less than one day: hr. min.

9. Birthplace: Norfolk Va. (Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Abraham
13. Birthplace: Lith.

MOTHER
14. Maiden Name: Annie
15. Birthplace: Lith.

16 (a) Informant: Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship
Location: Balto + Conklin Sts

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 (a) (Date received by registrar) SEP 20 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1945, at 5.40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1 1945, to 9-18 1945, and that I last saw h[illegible] alive on 9/18 1945.

Immediate cause of death: Lateral Sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: W Edmund Lewis
Address 3400 Hilton Rd Date signed 9/18/45

G32514 over 170C G32514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. Sgt. U.S. Army.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Wisconsin (b) County
(c) City or town MILWAUKEE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 N. 14th. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Schmidt

3 (b) If veteran, name war W.W.# 2

3 (c) Social Security Account No. 387-05-1437 ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	SINGLE

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1913

8. AGE: Years	Months	Days	If less than one day
~~about 32~~ 32 yrs. old ?			hr. min.

9. Birthplace MILWAUKEE WIS. (Town, county, and state)

10. Usual Occupation US. SOLDIER

11. Industry or business

FATHER
12. Name ? WALTER SCHMIDT
13. Birthplace ? MILWAUKEE, WIS

MOTHER
14. Maiden Name ? MARGARET BENZ
15. Birthplace ? MILWAUKEE, WIS.

16 (a) Informant US. ARMY
(b) Address POST. OFFICE BLGD. BALTO.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 24/45 (month) (day) (year)
(c) Cemetery or crematory VALHALLA CEMETERY MILWAUKEE WIS.
Location MILWAUKEE WIS.

18 (a) Funeral director Tillyard Zieler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) SEP 20 1945 (Date received by local registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1945 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Subarachnoid hemorrhage, traumatic

Due to

Other Conditions Multiple fractures, lacerations, abrasions, contusions, brain (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17-45 at 2:15 a. M.
(b) Where did injury occur? Wash. Blvd. & Rolling Rd
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto (?)

23. Signature Howard J. Meddis M.D. Medical Examiner.

Date signed 9-19-45

G32515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 10

G32515 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 S. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced.~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1884

8. AGE: Years	Months	Days	If less than one day
61	7	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Barber

FATHER
12. Name Tony Rose
13. Birthplace Italy

MOTHER
14. Maiden Name Louisa Cuneo
15. Birthplace Italy

16 (a) Informant Joseph Rose
(b) Address 1 S. Linwood ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 20 1945 (Date rec'd by Registrar) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19th 1945, at 11 30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 45 to Sept 19 45, and that I last saw him alive on Sept 18 1945.

Immediate cause of death

Chron. Myocarditis

Due to Chron: Interstitial Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Kent Smedley, M. D.
Address 2486 E Balto Date signed 9-19-45.

VS 150

632516

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 60

632516
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Bon Secours Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5300 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Pessaro
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Andrew Pessaro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15-1884

8. AGE: Years	Months	Days	If less than one day
61	—	4	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Roma
15. Birthplace Italy

16 (a) Informant Andrew Pessaro
(b) Address 5300 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-45 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Balto Md

18 (a) Funeral director George A. Farley
(b) Address Fulton & West Fayette Sts

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 20 1945

Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/1945 at 12.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15/1945 to 9/19/1945, and that I last saw her alive on 9/18/1945.

Immediate cause of death Pulmonary Edema (Metastatic to lung) — Duration 2 Mo.
Due to Generalized Carcinoma
Due to Gen'l Debility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 3/24/44
Major findings of operation: Carcinoma of Breast.
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Martin Jr. M. D.
Address Bon Secours Hosp Date signed 9/19/45

X

G32517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32517 Registered No. 472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Zone 3a

3 (a) FULL NAME J. Henry Pierson

3 (b) If veteran, name war no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Elise Pierson

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept 21. 1877

8. AGE: Years	Months	Days	If less than one day
67	11	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Builder

11. Industry or business

FATHER 12. Name Henry Pierson

13. Birthplace Germany.

MOTHER 14. Maiden Name Catherine Fulling

15. Birthplace Germany.

16 (a) Informant Anna Elise Pierson

(b) Address 1221 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-1945 (month) (day) (year)

(c) Cemetery or crematory London Park Cemetery

Location

18 (a) Funeral director Mr. Mrs. John W. Teufel Son

(b) Address 801 W. Fayette St.

19 (a) (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

SEP 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945, at 6 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/44 19 . to 9/19 1945 and that I last saw h alive on 9/18 1945.

Immediate cause of death Carcinoma of Lung

Duration 2

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Leeiler

Address 226 Hanover St Date signed 9/20/45

X

G32518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85a

G32518 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home & Infirmary

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA EPSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
80	6th		hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Harry
13. Birthplace Lith

MOTHER
14. Maiden Name Sarah
15. Birthplace Lith

16 (a) Informant Annette Schochett
(b) Address 4429 Pall Mall Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month) (day) (year)
(c) Cemetery or crematory Homer Cone
Location Logandale

18 (a) Funeral director Jack Lewis Inc
(b) Address 1431 E Balto St

19 (a) (Date rec'd by registrar) (b) (Registrar)

SEP 20 1945 Huntington Williamsport, Md

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1945, at 1A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1945 to 9-20 1945 and that I last saw h[illegible] alive on 9-20 1945

Immediate cause of death: Cerebral Haemorrhage — Duration: 1 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin

Address Levindale Date signed 9/20/45

X

G32519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY B. SCHRODETZKI

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Herman A. Schrodetzki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Stang
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Keller
15. Birthplace Germany

16 (a) Informant Mr. Bernard H. Schrodetzki
(b) Address 2836 Clifton Park Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 20 1945 (Date rec'd by registrar) (b) Huntington Williamsburg Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1945 at M

21. I certify that death occurred on the date above stated, that I attended deceased from April 1944 to Sept 1945.
and that I last saw h[illegible] alive on about 3 weeks ago.

Immediate cause of death: Coronary Thrombosis
Due to: Arteriosclerotic Cardio-Vascular Disease
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Stevens M.D.
Address 3400 Edmondson Ave. Date signed 9/22/45

VS 150

632520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

632520

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1546 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 Pennsylvania Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Nellie Bryant

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Frank

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-1-1879

8. AGE: Years	Months	Days	If less than one day
66	0	15	..... hr. ..... min.

9. Birthplace Buckingham Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Allen
13. Birthplace Buckingham Co., Va.

MOTHER
14. Maiden Name Nellie Allen
15. Birthplace Buckingham Co., Va.

16 (a) Informant Mrs. John Allen
(b) Address 2127 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location .....

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 20 1945 (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

28. DATE OF DEATH Sept. 16 1945, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Sept 16 1945, and that I last saw h[illegible] alive on Sept 16 1945

Immediate cause of death Cerebral Hemorrhage — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Jenkins & White M. D.
Address 1543 Penn Ave Date signed 9-20-45

VS 8

G32521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192

Registered No. G32521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 Caroline St.

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days. 9

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1611 Lamont Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Helen Marie Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17-1945

8. AGE: Years | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Avery N. Daniels

13. Birthplace Md.

MOTHER 14. Maiden Name Catherine C. Shade

15. Birthplace Md.

16 (a) Informant Mrs. Avery N. Daniels

(b) Address 1611 Lamont Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-22-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Maria

Location Baltimore Co.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Registrar

VS 1 SEP 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1945 at 6:41 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1945 to 9-20 1945; and that I last saw her alive on 9-20 1945.

Immediate cause of death Dehydration — Duration

Due to Infantile diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. N. Frank. M. D.

Address St. Joseph's Hosp. Date signed 9-20-45

632522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. 632522

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 E. Federal St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 E. Federal St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Parran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Luther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 6-1872

8. AGE: Years 73 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Henry Whitlock
13. Birthplace Va

MOTHER 14. Maiden Name Mary E. Whitlock
15. Birthplace Va

16 (a) Informant Luther Parran
(b) Address 402 E. Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 21 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date received by registrar) SEP 20 1945 (b) Huntington, Williamsburg, Md.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 45, at 8 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 19 45 to Sept 18 19 45, and that I last saw h alive on Sept 10 19 45

Immediate cause of death: Cerebral Hemorrhage — Duration 10 d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Kate O. Johnson M. D.
Address 2329 Guilford Ave Date signed Sept. 19. 1945

G4263 — 1525523

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. 21st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 W. 21st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James R. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54		1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER — 12. Name Boller Johnson
13. Birthplace Va

MOTHER — 14. Maiden Name Laura Hill
15. Birthplace Va

16 (a) Informant Jessie Johnson
(b) Address 130 W. 22 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Catonsville

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 20 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1945 at 4:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic hypertensive Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Medeiros M.D.
Medical Examiner.
Date signed 9-18-45

VS 151

G32524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G32524

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 919 BRUNSWICK ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 5
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Brunswick St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET A. HUGHES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wht | 6 (a) Single, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband ~~or wife~~ Wm A.

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec 6 1891

8. AGE: Years	Months	Days	If less than one day
53	10	13	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fred Stud
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Wm A. Hughes
(b) Address 919 Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Pk
Location Philadelphia

18 (a) Funeral director Geo H. Lembach
(b) Address 1725 N. Lynchburst Ave

(Date received) SEP 20 1945 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 at 8.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Sept 19 1945, and that I last saw her alive on Sept 19 1945.

Immediate cause of death Carcinoma of Liver — Duration 3 months

Due to Carcinoma of stomach

Due to

Other Conditions Cholelithiasis
(Include pregnancy within 3 months of death)

Date of operation Sept 5, 1945

Major findings of operation: Ca of Liver and Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Hermsen M. D.
Address 1934 Wilkens Ave Date signed

G32525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32525 Registered No. 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4809 Hamilton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME JACOB QUICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Bessie Quick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January '79

8. AGE: Years	Months	Days	If less than one day
66	8		hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Balto. City Employee

11. Industry or business

FATHER

12. Name Peter Quick

13. Birthplace Germany

MOTHER

14. Maiden Name Louise Reisler

15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Casper Sippel

(b) Address 5436 Belair Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 21, 1945 (month) (day) (year)

(c) Cemetery or crematory Jerusalem

Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home

(b) Address 7401 Belair Road

18 (c) Huntington Williams, M.D. (Signature of registrar)

SEP 20 1945 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1945, at 1.22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/18 1945 and that I last saw him alive on 9/18 1945.

Immediate cause of death Bronchopneumonia

Due to aspiration

Due to

Other Conditions Cardiac failure, cholelithiasis, multiple lung infarcts

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Daniel Hamburger M.D.

Address Sinai Hospital Date signed 9/18

G32526 BALTIMORE CITY HEALTH DEPARTMENT X G32526
CERTIFICATE OF DEATH 83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life-42yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Overlea Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6709 Linden Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Anne E. Hess
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Hall Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1903

8. AGE: Years 42 | Months 4 3 | Days 17 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Jasper
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Millhauser
15. Birthplace Md.

16 (a) Informant Hall Hess
(b) Address 6709 Linden Ave, Overlea Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22 1945 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Baltimore

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) SEP 20 1945 (b) Filed by registrar Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1945, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1945 to 9/19 1945, and that I last saw her alive on 9/19 1945.

Immediate cause of death Respiratory failure — Duration

Due to Hypertension with the Cerebral Vascular accident — 9/17/45

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C H Bailey M. D.
Address Mercy Date signed 9-19-45

G32527

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119A

G32527
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — St Elizabeths Home
(b) Street address — Allendale Ave
(c) Hospital or institution — St Elizabeths Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days) — Life

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County
(c) City or town — Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. — 3725 Allendale Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME — Joseph Anthony Contee
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — Jan. 21st 1943

8. AGE: Years	Months	Days	If less than one day
	7	28	hr. min.

9. Birthplace — Balto, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name — George Brown
13. Birthplace — Unknown

MOTHER
14. Maiden Name — Hilda Contee
15. Birthplace — Balto, Md.

16 (a) Informant — Hilda Contee
(b) Address — 1147 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — Sept. 21st 1945 (month) (day) (year)
(c) Cemetery or crematory — Mt Calvary
Location — B. A. Co. Md.

18 (a) Funeral director — Belsom, Hamilton & Wright
(b) Address — 721 Aisquith St

19 (a) (Date received by registrar) (b) Registrar

SEP 20 1945
Vs 5 Hunterstown Hillsboro Md

MEDICAL CERTIFICATION

20. DATE OF DEATH — 9/19 1945, at 4:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1945 to 9/19 1945 and that I last saw h[illegible] alive on 9/19 1945

Immediate cause of death — Drainhose of Infancy.
Due to — Intestinal upset - General Prostration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature — Dorah J. Roberts
Address — 1029 N. Paul St Date signed — 9/19/45 M. D.

G32528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

G32528 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Arthur Ringgold

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-8300

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	0	15		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Ice Cream Company

FATHER
12. Name Fredrick
13. Birthplace Balto, Md

MOTHER
14. Maiden Name ? Wilhelm
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Barbara
(b) Address 2936 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date rec'd by registrar) (b)
SEP 20 1945
Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1945 at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1945 to 9/18 1945 and that I last saw him alive on 9/18 1945.

Immediate cause of death
Resp. Failure
Due to Pulmonary Embolism.
Due to Carcinoma of Head of Pancreas.
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Oscar E. Carroll Jr. M.D.
Address 1 St. Agnes Hosp. Date signed 9/18/45

G32529 YENTER G32529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 S. Tolcroft St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S. Tolcroft St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Yenter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Lotta Yenter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	14	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Electrotyper

11. Industry or business

FATHER
12. Name —
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Retney Bohner
(b) Address 323 S. Tolcroft St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1945 at 11 45 PM

21. I certify that I took charge of the remains described above, held an 9 + 8 thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic
CVD

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L Sherman M.D.
Medical Examiner.
Date signed 9/19/45

G32530

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 164C

G32530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Sudbrook Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Muntz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1901

8. AGE: Years	Months	Days	If less than one day
44	1	5	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER 12. Name Thomas P. Muntz

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Anna D. Coakley

15. Birthplace Balto.

16 (a) Informant Mrs. Mary Muntz

(b) Address 115 Sudbrook Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Palmer St.

19 (a) SEP 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1945, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of chest & abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17-45 11 A. M.
(b) Where did injury occur? 115 Sudbrook Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self with Shot-gun

23. Signature George R. Callender, M.D. Medical Examiner.
Date signed 9-18-45
For J. R. Davis, M.D.

Issued by: Howard F. Madden, M. D.

G32531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32531

Registered No.

CMK-12029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10- 8- 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 68- 1- 22-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2527 Fait Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68	1	22	hr. min.

9. Birthplace Baltimore-Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alvin Jenkins
13. Birthplace West Indies

MOTHER
14. Maiden Name Mary Weber
15. Birthplace Baltimore-Md.

16 (a) Informant Records-Balto. City Hospitals.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 20 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1945, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1945 to Sept. 4 1945, and that I last saw h. in alive on Sept. 4 1945.

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave. Date signed 9-17-45

F 2970

VS 150

G32532 Birth 9-3 1903

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G32532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Green
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balt.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Pine (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ida May Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7. 1945

8. AGE: Years | Months | Days: 10 | If less than one day: 6 hr. min.

9. Birthplace: Baltimore, MD. (Town, county, and State)

10. Usual Occupation: Student

11. Industry or business: +

FATHER
12. Name: Oliver Scott
13. Birthplace: Baltimore, MD

MOTHER
14. Maiden Name: Ida McKee
15. Birthplace: Charlotte, N.C.

16 (a) Informant: Father
(b) Address: 109 N. Pine St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: UNIVERSITY MEDICAL SCHOOL
Location: SEP 20 1945

18 (a) Funeral director: Commissioner of Health
(b) Address:

19 SEP 20 1945 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 9-17 1945, and that I last saw h[illegible] alive on 9-17 1945

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: G. B. Haney M. D.
Address: Date signed

VS 150

2972

G32533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G32533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover Sts.
(c) Hospital or institution: University Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Madison Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Baby Girl Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-7-45

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Charles O'Donald Holley
13. Birthplace Kelford, N. Car.

MOTHER
14. Maiden Name Delores Ernestine Gray
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 245

20. DATE OF DEATH 9-7 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1:45 p.m. 9-7 1945 to 2:45 p.m. 9-7 1945 and that I last saw h.e.r alive on 2:45 p.m. 9-7 1945

Immediate cause of death Premature

Due to Abortion - spontaneous cause unknown.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy no

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Norment III M.D.
M. D.

Address Univ. Hosp. Date signed 9-7-45

VS 8

2971

G32534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G32534

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4301 Roland Avenue

(c) Hospital or institution: Kirkleigh Villa.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4301 Roland Ave.

(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. Roeder

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife * * *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1865

8. AGE: Years	Months	Days	If less than one day
79	9	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name J. Hartman Roeder

13. Birthplace Germany

MOTHER

14. Maiden Name Barbara Dechelbofo

15. Birthplace Alsace Lorraine, France

16 (a) Informant Miss Mary G. Sehlhorst

(b) Address 701 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Chas. J. Evans & Son

(b) Address 1111 N. Mt. Royal Ave

(a) SEP 20 1945 Washington, Maryland

(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940. to Sept 19 1945.

and that I last saw her alive on Sept 19 1945.

Immediate cause of death	Duration
Chronic myocarditis	4 yrs.
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. Irma Mooney M. D.

Address 3105 Belair Rd Date signed 9-20-45

VS 150

G32535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120 A

G32535

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 Hudson Rd
(c) Hospital or institution: Greenlawn Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Hamilton Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mrs Mae R Snyder

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widow

6 (b) Name of husband or wife Wm R. Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 7 - 1882

8. AGE: Years	Months	Days	If less than one day
63	8	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Woman Wife
11. Industry or business

FATHER
12. Name Emanuel B Bullock
13. Birthplace Md

MOTHER
14. Maiden Name MARY E COLLEY
15. Birthplace BALTIMORE

16 (a) Informant W. Rayner Snyder
(b) Address 3103 Sumter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans Son
(b) Address 1616 N. Mt Royal Ave.

19 (a) SEP 20 1945 (Date rec'd by registrar) (b) Registered Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945, to Sept 18 1945, and that I last saw h alive on Sept 18 1945.

Immediate cause of death	Duration
Obstruction	24 hrs
Due to Acute Diarrhoea	24 hrs
Due to General Depletion of Long Duration	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wayne D. Kennedy M. D.
Address 3702 Hudson Rd City Date signed 9-18-45

VS 3

G32536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 HARFORD AVE.
(c) Hospital or institution:
CONVALESCENCE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S MONROE STREET (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA E. SNYDER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Albert S. Snyder.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5 - 1875

8. AGE: Years 69 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Martinsburg W. Va.
(Town, county, state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name George Roberts
13. Birthplace Martinsburg W. Va.

MOTHER
14. Maiden Name Elizabeth Rench
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Alvin S. Snyder.
(b) Address 316 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 W. Lombard

19 (a) (Date received by registrar) (b) Registered

SEP 20 1945

VS 100 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 18 1945, at 1. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 28 1945 to SEPT 18 1945 and that I last saw her alive on SEPT 18 1945.

	Duration
Immediate cause of death: APOPLEXY AUGUST 28 1945. (2nd STROKE.)	
Due to: ARTERIOR SCLEROSIS	1945
Due to: CHRONIC MYOCARDITIS	1945.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Chantler M. D.
301 ST PAUL STREET SEPTEMBER 18. 19
Address Date signed

G32537 Maloney G32537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hammonds & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give County)
(d) Street No. 1910 E. Oraft Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick H. Maloney.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-3431

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 9-1870

8. AGE: Years	Months	Days	If less than one day
75	0	10	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Pat Maloney
13. Birthplace Ireland

MOTHER
14. Maiden Name Annastasia Leleary
15. Birthplace Ireland

16 (a) Informant Elizabeth Maloney
(b) Address 1910 E. Balto 24

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)
(c) Cemetery or crematory New Loath.
Location Old Frederick Rd.

18 (a) Funeral director John J. Jordan
(b) Address 3410 E. Balto. St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 9-19 1945, and that I last saw h alive on 9-19 1945.

Immediate cause of death Pulmonary edema
Bronchopneumonia — Duration

Due to Coronary sclerosis - replaced

Due to Autointoxication cardiac vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L Rowell
Address Sinai Hospital Date signed 9-19-45 M. D.

VS 150

G32538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32538 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Oxford (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Market St, (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John William Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 45

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Dan Williamson Kennedy
13. Birthplace Illinois

MOTHER
14. Maiden Name Margaret Triplett
15. Birthplace Maryland

16 (a) Informant Margaret Kennedy
(b) Address Oxford, Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 45 (month) (day) (year)
(c) Cemetery or crematory Oxford Cem.
Location Oxford, Pa.

18 (a) Funeral director J. E. Lynch
(b) Address Oxford, Pa.

19 (a) Sept 20 1945 (b) Huntington Williams, M.D. Registrar
Date received by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1945 at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1945, to Sept. 20 1945, and that I last saw him alive on Sept. 20 1945.

Immediate cause of death	Duration
Respiratory arrest	
Due to meningococcemia	
Due to meningococcus meningitis	2 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Streeter M. D.
Address Union Memorial Hospital Date signed 9-20-45

G32539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G32539
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Rural Myersville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Welty M. Stottlemyer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) May 20, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	1	hr. min.

9. Birthplace Myersville Frederick Co., Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

MOTHER | FATHER
12. Name Clarence Stottlemyer
13. Birthplace Myersville, Md.
14. Maiden Name Lydia Wareanfeltz
15. Birthplace Walkersville, Md.

16 (a) Informant Levi Stottlemyer
(b) Address Waynesboro, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-45 (month) (day) (year)
(c) Cemetery or crematory Crossnickel Cem.
Location Myersville, Md.

18 (a) Funeral director Ahalt Bros.
(b) Address Middletown, Md.

SEP 21 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1945, at 12 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1945, to 9-21 1945, and that I last saw him alive on 9-21 1945

Immediate cause of death Cardiac failure — Duration 4 hrs.
Due to Uremia — 5 days
Due to Kidney dis. - ch. Glom. nph. —
Other Conditions Pulmonary Edema — 6 hrs

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene N. Conaway M. D.
Address Univ. Hosp. Date signed 9-21

G32540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32540

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 21-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 W. Hamburg St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August A. Wyatt

3 (b) If veteran, name war: —

3 (c) Social Security Account No. 213-01-8617

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Fannie Wyatt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st 1893

8. AGE: Years	Months	Days	If less than one day
52	3	18	hr. min.

9. Birthplace Dover, Delaware (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Apex Wood Co.

FATHER
12. Name (Not Known) Wyatt
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Margaret Davis
(b) Address 602 W. Hamburg St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul st.

SEP 21 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945, at 10 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 19 1945, and that I last saw h[illegible] alive on Sept 19 19 45.

Immediate cause of death: Empyema Duration

Due to Hypertension and cardiac arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Schulz

Address Sinai Hospital Date signed 9 17 M. D.

G32541 to Permit

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 A

Registered No. G32541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6515 Philadelphia Rd
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) ~~City~~ or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6515 Philadelphia Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie F. Charles

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
6 (b) Name of husband: Ezra B. Charles
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 9th 1894
8. AGE: Years: 50 | Months: 9 | Days: 11 | If less than one day: hr. min.
9. Birthplace: Forsyth Co. N.C. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: James Hege
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Frances C. Byerly
15. Birthplace: N.C.

16 (a) Informant: Ezra B. Charles
(b) Address: 6515 Phila. Ave
17 (a) Removal (Burial, ~~cremation~~ or removal)
(b) Date thereof 9/21/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Guilford Memorial
Location: High Point N.C.
18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st.
19 (a) 9 21 1945 (Date received by registrar) Huntington Williams M.D.
(b) Registrar's No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20th 1945, at 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1944 to 9-20 1945 and that I last saw h~~im~~ alive on 9-20 1945.

Immediate cause of death: apoplexy — Duration 2 hrs
Due to: hypertension — Duration
Due to: Arteriosclerosis — Duration
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Tom Deen M.D.
Address 324-12 [illegible] Date signed 9/21/45

VS 190

2 G32542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G32542 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 McDonough St
(c) Hospital or institution:

7-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 McDonough St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Moody

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife Sherman
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) August 8, 189?

8. AGE: Years	Months	Days	If less than one day
48	1	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Moses Moody
13. Birthplace Va

MOTHER
14. Maiden Name Cora Bailey
15. Birthplace Va

16 (a) Informant Dorothea Fallin Skinner
(b) Address 937 McDonough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Mrs. Robert A. Eldridge
(b) Address 1129 N. Caroline St.

19 SEP 21 1945 (b) (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1945 at 10.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1945 to 9-19 1945 and that I last saw her alive on 9/18 1945

Immediate cause of death Hypertensive cardio-renal disease — Duration: unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne
Address 1502 E. Madison St Date signed 9/24

Rayner Browne

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REF #96076 G32543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32543 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 18-5-4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Bloom Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

14-3

3 (a) FULL NAME S. Bernard Fredericks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1927

8. AGE: Years	Months	Days	If less than one day
18	5	4	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name William Fredericks
13. Birthplace Maryland

MOTHER
14. Maiden Name Grace Scovans
15. Birthplace Washington

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director John M. Johnson
(b) Address 1700 Druid Hill Ave

19 (a) SEP 21 1945 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19th, 1945 at 3:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1945 to Sept. 19, 1945, and that I last saw him alive on Sept. 19, 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert K. Copeland M. D.
Address Balto. City Hosp. Date signed 9/20/45

Washington Williams, M.D.

G32544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 157E

Registered No. G32544

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOCTORS HOSP.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 298 GLENHURST ROAD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DONNA ELIZABETH Boddeford.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 14 1945

8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name GLEM BODDIFORD
13. Birthplace GEO.

MOTHER
14. Maiden Name JULIA PIEZONKI
15. Birthplace BALTO.

16 (a) Informant CLEM BODDIFORD (FATHER)
(b) Address 298 GLENHURST ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 21/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Selby & Zeiler Inc.
(b) Address 403 S. MOLFE ST.

19 (a) (Date rec'd by reg.) SEP 21 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20-1945, at 5/40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1945 to Sept. 20 1945, and that I last saw her alive on Sept 20 1945.

Immediate cause of death: Heart Disease Congenital — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Gilbert, M.D.
Address 109 Trophe Rd Date signed 9/20/45

G32545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G32545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Collins Ave. Balt. 29 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edgar Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mary V. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 21, 1886

8. AGE: Years	Months	Days	If less than one day
58	8/11	30	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Operator for
11. Industry or business Baltimore Transit Co.

FATHER
12. Name John Miller
13. Birthplace Md

MOTHER
14. Maiden Name Mary Warrington
15. Birthplace Md.

16 (a) Informant Mary Miller
(b) Address 1445 S. Collins Ave Balt. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George A. Fearley
(b) Address Fulton Ave & Fayette St.

19 (a) SEP 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1945, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1945, to Sept 20 1945, and that I last saw him alive on 9/20 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Heart Failure	9/20/45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pericardial effusion (serous) Pericardium Adherent; Atherosclerosis moderate (Signs of previous coronary occlusion)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.H. Bailey M. D.
Address Mercy Hospital Date signed 9/20/45

VS 150

Huntington Williams, M.D. (over)

G32546 Lottie Levinia Agnes Condon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G32546 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John st.
(c) Hospital or institution:
Hospital for Women of Maryland 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo 16 day
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 W. Mosher st. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Lottie Levinia Agnes Condon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1869

8. AGE: Years	Months	Days	If less than one day
76 yrs	5	4	hr. min.

9. Birthplace Newark, N. J. (Town, county, and state)
10. Usual Occupation Retired - clerk
11. Industry or business Hochschild, Kohn & Co.

FATHER
12. Name George H. Condon
13. Birthplace unknown N.Y.C.

MOTHER
14. Maiden Name Mary Elizabeth Rankin
15. Birthplace unknown Newark, N.J.

16 (a) Informant Mrs. Rosa N. Eichelberger
(b) Address 306 Lexington Ave. - N.Y.C. - 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/46 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location 3401 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (b) Huntington Willemette, M.D. Registrar

Sep 21 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1946; at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1946, to Sept 20 1946, and that I last saw h[illegible] alive on Sept 19 1946.

Immediate cause of death Cardiac Asystole Jaundice

Due to Generalized dilatation arose & Generalized

Due to Metastatic carcinoma primary Carcinoma Colon.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration
(?)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Palmer

Address Hosp for Women of Md Date signed 9/20/46 M.D.

G32547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G32547 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Fleetwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Margaret Pasquith

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Auston B.
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 21

8. AGE: Years	Months	Days	If less than one day hr.	min.
63	9	29		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Nicholas Donnerlein
13. Birthplace Germany

MOTHER
14. Maiden Name Jenny Gerlach
15. Birthplace Germany

16 (a) Informant Auston B. Pasquith
(b) Address 2915 Fleetwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Winsor Mill Rd

18 (a) Funeral director M. W. K. Uppal's Sons
(b) Address 1 N. Gay & Fayette St.

19 (a) SEP 21 1945 (Date rec'd by registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1945, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1945 to 9/20 1945, and that I last saw her alive on 9/20 1945.

Immediate cause of death	Duration
Cardiac Failure	1 day
Due to Coronary Occlusion	2 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin H. Honeyman M.D.
Address University Hospital Date signed 9/20/45

632548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 D

Registered No. 632548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 N. 36th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 8
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 N. 36th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Franklin Bossom

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Maggie V. Bossom
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 27-1867
8. AGE: Years 78 | Months — | Days 22 | If less than one day hr. min.
9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business City of Baltimore

FATHER
12. Name Charles Bossom
13. Birthplace Maryland

MOTHER
14. Maiden Name Cecelia Harris
15. Birthplace Maryland

16 (a) Informant Mrs. Maggie V. Bossom
(b) Address 1423 N. 36th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24-1945 (month) (day) (year)
(c) Cemetery or crematory Lineboro
Location Lineboro, Carroll Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date received by Registrar 9 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19- 1945, at 12 23 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1945 to 9/19 1945 and that I last saw h[illegible]live on 9/19 1945

Immediate cause of death	Duration
Hemiplegia	3 Days
Due to arteriosclerosis	4 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2020 N. Charles Date signed 9/20/45

VS 150

G32549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32549

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Somerset St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Somerset St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert Watkins
13. Birthplace N. C.

MOTHER
14. Maiden Name Octavia Alexander
15. Birthplace N. C

16 (a) Informant Robert Taylor
(b) Address 824 Somerset St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dgh.
(b) Address 1129 N. Caroline St.

SEP 21 1945 (Date filed by registrar)

(a) Thomas for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 19 1945 and that I last saw h alive on Sept 19 1945

Immediate cause of death Lobar Pneumia — Duration 14 Days

Due to Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Walters M. D.
Address 1443 E Eager Date signed 9/21/45

VS 150

G32550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4318 Roland Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Balto. City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4318 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? No, (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Cook Steiger

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Andrew W. Steiger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1858

8. AGE: Years	Months	Days	If less than one day
87	7	34	hr. min.

9. Birthplace Simsbury, Conn.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Cook
13. Birthplace Simsbury, Conn.

MOTHER
14. Maiden Name Rebecca Middleton
15. Birthplace Simsbury, Conn.

16 (a) Informant Mrs. Frank J. Howland
(b) Address 4318 Roland Av. - City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9. 15 (month) (day) (year)
(c) Cemetery or crematory Simsbury - Centre Cem.
Location Simsbury Conn.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 106 W. NORTH AVENUE

19 SEP 21 1945 (Date rec'd by registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1945 at 11.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1941 to July 1945 and that I last saw her alive on July 17 1945.

Immediate cause of death	Duration
Coronary Occlusion	Sev. hrs.
Due to Hypertensive Arteriosclerotic Heart Disease	Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert W. Garis M. D.
Address 1014 St. Paul St. Date signed 9/20/45

VS 190

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

Mary C. Kimmitt Lannon

632551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 632551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Barclay St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Kimmitt Lannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63	-	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Rodger Kimmitt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Miss Celeste Lannon
(b) Address 2102 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary W. Wiedefeld
(b) Address 501 E. 32nd St.

1945 SEP 21 1945 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1943 to Sept 19 1945, and that I last saw h[illegible] alive on Sept 15 1945.

Immediate cause of death Carcinoma of Breast — Duration 2 yrs

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Callena M.D.
Address 3321 Fredericks Ave Date signed 9/21/45

X

G32552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

G32552 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. East Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

6 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. East Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA NORWOOD

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank P. Norwood
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1884

8. AGE: Years	Months	Days	If less than one day
61	7	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Conrad Friedel
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Hahn
15. Birthplace Germany

16 (a) Informant Frank P. Norwood
(b) Address 102 N. East Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 220 E. Orleans St.

SEP 21 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20, 1945 at 1155 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Sept. 20 1945, and that I last saw him alive on Sept. 20 1945.

Immediate cause of death: acute myocardial insuf. — Duration: 4 hrs.

Due to: coronary occlusion — 1 mo.

Due to:

Other Conditions: hypertension — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. C. Sollod M.D.

Address 447 N. Kenwood Ave. Date signed 9/21/45 M. D.

VS 150

G32553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119A

Registered No. G32553

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hollywood & Cream
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/45

8. AGE: Years	Months	Days	If less than one day
		19 18	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jeannie Davis

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Gladys

15. Birthplace Baltimore

16 (a) Informant Gladys Davis

(b) Address 1738 N. Calhoun St

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/21/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md

18 (a) Funeral director Wm. Geo. Mc Holland

(b) Address 601 Druid Hill Ave

19 (a) (Date received by local registrar) (b) Huntington Williams M.D.

SEP 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~9/18~~ 9/18 1945, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1945, to 9/18 1945, and that I last saw him alive on 9/18 1945.

Immediate cause of death Toxemia, acidosis — Duration

Due to diarrhea

Due to prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mark M. D.

Address Univ. Hosp Date signed 9/24/45

G32554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G32554 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 13
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham S. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 66 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Cutter

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: Russia

MOTHER
14. Maiden Name: unknown
15. Birthplace: Russia

16 (a) Informant: Mrs Alfred Mazor
(b) Address: 3765 Columbus Drive

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)

(c) Cemetery or crematory: Workmen Circle
Location: New Mt. Carmel
Jacob Lewis Inc

18 (a) Funeral director
(b) Address: 1429 E. Balto. St

19 (a) SEP 21 1945 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to 9/16 1945 and that I last saw h alive on 9/16 1945

Immediate cause of death: Acute coronary insufficiency — Duration

Due to: Chronic nephritis

Due to: Acute cardiac failure

Other Conditions: Ch myocarditis

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Bornstein M. D.
Address 733 Argyle St Date signed 9/24/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

632555

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

632555 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 3909 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Dave

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Leon
13. Birthplace Poland

MOTHER 14. Maiden Name Sarah
15. Birthplace Poland

16 (a) Informant Jack Levin Inc
(b) Address 1739 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Baltimore St

SEP 21 1945

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 9/21 1945; and that I last saw him alive on 9/21/1945.

Immediate cause of death: Cardio-Renal Vascular Disease — Duration 10 yrs

Due to

Due to

Other Conditions: Cerebral Hemorrhage — Duration 2 weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. Sarahan M.D.
Address 2128 W. North Ave Date signed 9/21/45

VS 150

G32556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G32556

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Pulaski St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 319 S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Felter

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-01-3475

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1912

8. AGE: Years 33 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Brush Factory

FATHER 12. Name Frederick W. Felter

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Anna M. Back

15. Birthplace Baltimore Md

16 (a) Informant Frederick W. Felter

(b) Address 319 S. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 - 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balt Co

18 (a) Funeral director B. M. Walters

(b) Address Pratt & Fremont Sts

19 (a) SEP 21 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Sept 19 1945 and that I last saw h[illegible] alive on Sept 19 1945.

Immediate cause of death	Duration
Acute Cardiac Dilatation	Hrs
Due to Labor & pregnancy Rt Pharmacy	14 days
Due to Infection	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Haywood Kahn M.D.

Address 707 W Mulberry Date signed 9/20/45

X

G32557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G32557 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 S. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 S. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara M. Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph W

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28. 1869

8. AGE: Years 76 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Sigmond Hasselberger
13. Birthplace Germany

MOTHER
14. Maiden Name — ?
15. Birthplace Germany

16 (a) Informant Margaret A. Schultz
(b) Address 213 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Q. Q. Co. Md.

18 (a) Funeral director Robt C. & B.M. Walters
(b) Address Pratt & Stricker St.

19 (a) SEP 21 1945 (Date rec'd by registrar) (b) Washington Boulevard, Md. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH Sept 19 1945 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 19 1945 and that I last saw her alive on Sept 19 1945.

Immediate cause of death Uremia — Duration 2 days

Due to Chronic Nephritis — 6 mos.

Due to Arterio Sclerosis — 1 yr.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Mattie M.D.

Address 1279 William N Date signed 9/20/45

VS 180

MRS. DICE

G32558

DICE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G32558

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2439 Dorton et.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2439 Dorton et

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret A Dice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Sep M.

6 (b) Name of husband or wife Lewis Dice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day hr.	min.
60				

9. Birthplace Eckhart Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Crowley

13. Birthplace Md.

MOTHER 14. Maiden Name Mary McMahon

15. Birthplace Md.

16 (a) Informant Lewis Dice

(b) Address 2439 Dorton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/45 (month) (day) (year)

(c) Cemetery or crematory Loudoun Md

Location Allegany Co

18 (a) Funeral director Edward Faulkner

(b) Address 215 Preuk Blvd

SEP 21 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

Approved: Chester F. Lubinski M.D. per Robert Lee Hunter M.D. X

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1945, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20, 1945, to Sept. 20 1945, and that I last saw her alive on Sept. 20 1945.

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 6 hrs

Due to Hypertensive Vascular Disease — yrs?

Due to

Other Conditions generalized cerebral arteriosclerosis.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edgar F. Hunter

Address 2623 Washington Blvd Date signed 9/21/45

G32559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32559

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County City
(c) City or town City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 844 W Balto. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Chadwich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Texas (Town, county, and State)

10. Usual Occupation Hedmaker

11. Industry or business Foster Bros.

FATHER
12. Name mother

13. Birthplace

MOTHER
14. Maiden Name mother

15. Birthplace

16 (a) Informant none

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a) SEP 21 1945 (Date received by registrar) (b) Huntington Williams, M.D.

UNIVERSITY MEDICAL SCHOOL SEP 21 1945
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1945, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1945, to 9/17 1945, and that I last saw h/ m alive on 9/17 1945.

Immediate cause of death

	Duration
ventricular tachycardia	12 hrs.
Congestive failure	2-3 mo.
Due to degenerative heart disease ?	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P Daemes M.D.

Address University Hosp. Date signed 9/21/45

VS 150

F 2973

632560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

101

632560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen G. Nelson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1945

8. AGE: Years	Months	Days	If less than one day
	5	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Byers
13. Birthplace Columbia, S.C.

MOTHER
14. Maiden Name Helen Nelson
15. Birthplace 503 S. Ensor Street

16 (a) Informant Helen Nelson
(b) Address 503 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wilson Conroe
(b) Address 217 E. Fort Ave.

19 (a) (Delivered to registrar) 9-22-1945 (b) Huntingtown, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1945, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Lobular Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fortson M.D. Medical Examiner.
Date signed Sept. 21, 1945

G32561

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1197

G32561
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Evergreen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph G. Gooch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	--

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1945

8. AGE: Years	Months	Days	If less than one day
0	3	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Goma C. Gooch
13. Birthplace Texas

MOTHER
14. Maiden Name Theona Kube
15. Birthplace Balto., Md.

16 (a) Informant Mr. Goma Gooch
(b) Address 2806 Evergreen Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director Lonsdale Funeral Home
(b) Address 7401 Belair Road

19 (a) 9-22 1945 (Date received by registrar) by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1945, at 6 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1945 to 9-20 1945 and that I last saw him alive on 9-20 1945.

Immediate cause of death — Duration

Cardio-Respiratory Failure

Due to Dehydration

Due to Diarrhoea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. C. Robertson M. D.
Address St. Joseph Hosp Date signed 9-20-45

VS 180

G32562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32562 Registered No.

PRINT OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 N. Wickham Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 N. Wickham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-4385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma J. Bowers
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) September 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	-	18	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Hercules Co.

FATHER
12. Name Jesse L. Bowers
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Upton
15. Birthplace Maryland

16 (a) Informant Mrs. Emma J. Bowers
(b) Address 5 N. Wickham Road

17 (a) Burial (b) Date thereof Sept. 22, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Ramsburg
(b) Address 4510 Liberty Heights Ave.

19 (a) 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1945, at 4.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 20 1945, and that I last saw h. alive on Sept 20 1945.

Immediate cause of death	Duration
Carcinoma of Liver	4 mos
Due to Chronic Nephritis	2 yrs
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos J. Abbott M. D.
Address 4509 Liberty Hgts Ave. Date signed

G32568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G32563

CWK-96110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1427 Bounty Lane (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Virgil Lovings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Douglas Snell (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1904

8. AGE: Years	Months	Days	If less than one day
40	8	14 24	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name William Lovings

13. Birthplace Virginia

MOTHER

14. Maiden Name Lucy White

15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept. 22 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Baltimore, Md.

18 (a) Funeral director Walter D. Briggs

(b) Address 639 W. Hamburg St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 19 1945, at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16 1945, to Sept. 19 1945, and that I last saw h. alive on Sept. 19 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert B. Borland Jr. M. D.

Address Balto. City Hosp. Date signed 9/20/45

VS 150

G32564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G32564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Street
(c) Hospital or institution: Mercy Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. High Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas E. Bersterman

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th., 1938

8. AGE: Years	Months	Days	If less than one day
7	4	16	###### hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Leo Joseph Bersterman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret A. Mullen
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret A. Bersterman
(b) Address 24 S. High Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue, Balto; Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date rec'd by registrar) (b) Registrar
SEP 22 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1945, at 7:63 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept 20 1945 3-2 M.
(b) Where did injury occur? Jones Falls & Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fell into Falls & drowned

23. Signature Howard J. Williams M.D. Medical Examiner.

Date signed 9-21-45

G32565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32565 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 E. Preston St.
(c) Hospital or institution: 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jannie Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife Willie Jackson

6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1886

8. AGE: Years	Months	Days	If less than one day
59	00	19	hr. min.

9. Birthplace Sussex County Va. (Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business

FATHER 12. Name Joe Taylor.
13. Birthplace Unknown

MOTHER 14. Maiden Name Susanna Cook
15. Birthplace Unknown.

16 (a) Informant Mary Williams
(b) Address 1214 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Joseph D. Lucky Jr.
(b) Address 1304 N. Central Ave

19 (a) 9-22-45 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1945 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 21 1945. and that I last saw h[illegible] alive on Sept 21 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to Hypertensive Cardiac Vascular disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. K. Adams M.D.
Address 1222 N. Carolina Date signed 9-21-45

VS 150

Huntington Hill

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

632566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood + Green St
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 19 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County: Anne Arundel
(c) City or town: Severn, Md. R.F.D. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No.: [illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: M. Jane Dyson.

3 (b) If veteran, name war:

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife: James W. Dyson
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): July 25, 1880

8. AGE: Years	Months	Days	If less than one day hr.	min.
65	1	24		

9. Birthplace: Penfield, Md. A.A. Co.
(Town, county, and state)
10. Usual Occupation: Merchant.
11. Industry or business: General Store

FATHER
12. Name: Benjamin F. Pumphrey
13. Birthplace: P.A. Co. Md.

MOTHER
14. Maiden Name: Minnie Myers
15. Birthplace: A.A. Co. Md.

16 (a) Informant: Benjamin F. Pumphrey
(b) Address: Severn, Md. R.F.D. 2

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof:** Sept 24, 1945 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Brooklyn, Md.

18 (a) Funeral director: Thomas W. Simpers
(b) Address: Glen Burnie, Md.

19 SEP 22 1945 (Date rec'd by registrar) (b) Washington Williams, M.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/21 1945, at 12:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1945 to 9/21 1945 and that I last saw her alive on 9/21 1945.

Immediate cause of death: Circulatory Failure — Duration: 1 month
Due to: Hypertension Cardio-Vascular disease — Duration: Unknown
Due to: — Duration: [illegible]
Other Conditions: Amputation - left arm - thigh
(Include pregnancy within 3 months of death)
Date of operation: 9/17
Major findings of operation: Arterial Embolism left femoral artery
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Alvin H. Hayman M.D.
Address: Univ. Hospital Date signed: 9/24/45

VS 180

G32567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 D

G32567 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 S. Collington ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Collington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Michael Misiszuk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Margaret Goldberg
(b) Address 2040 Bank Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 24 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) SEP 29 1945 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1945, at 6 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1945 to Sept. 19 1945, and that I last saw him alive on Sept 19 1945.

Immediate cause of death Carcinoma of lung

Due to primary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
✓ Mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farms, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Douglas M.D.
Address 1000 N. Eutaw St. Date signed 9/25/45

632568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. 632568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reviewed for correct spelling. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 402 E North Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 402 E North Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hellman Pratt Pascal

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie H Pascal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1890

8. AGE: Years 55 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Electrical Contractor

11. Industry or business Self

FATHER

12. Name Unknown

13. Birthplace "

MOTHER

14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Catherine Stickley

(b) Address 2503 Gordon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Govans Md

18 (a) Funeral director Nathan Ort Inc

(b) Address 1317 St Paul St

19 (a) SEP 22 1945 (Date rec'd by registrar) (b) Huntington W Va Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Sept 1945 and that I last saw h living on Sept 21 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Reginald J Tonry M.D.

Address 414 E North Ave Date signed Sept 22 1945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo. 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Tyson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	5	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business

FATHER
12. Name George Davis
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Maryland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Adolph Hadtt
(b) Address 918 Druid Hill Ave

19 (a) (Signature of Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1945 at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to Sept. 19 1945 and that I last saw him alive on Sept. 19 1945

Immediate cause of death Bronchopneumonia — Duration 3 wks.

Due to Arteriosclerotic Heart Disease — 5 yrs.

Due to

Other Conditions Pernicious Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 9940 Eastern Ave Date signed 9-19-45

VS 150

632570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ft. McHenry
(c) Hospital or institution: 9.7
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 Kirk Avenue (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK POEHLMAN

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-03-8385

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Lula M. Poehlman
6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): May 30, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	18	____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Truck Driver
11. Industry or business: Delvale Ice Cream Co.

FATHER
12. Name: Conrad Poehlman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Lina Shuler
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Lula Poehlman
(b) Address: 2543 Kirk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore County

18 (a) Funeral director: HENRY SANDER & SONS
(b) Address: NORTH AVE & BROADWAY

19 (a) 9-9-1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1945, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above at 4:30 P.M. in my opinion resulted from: Natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pulmonary Edema; Pulmonary Emphysema, Marked

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury FOUND: 3:30 P.M. at 9-18-45 M.
(b) Where did injury occur? FORT McHENRY - DELVALE DAIRY TRUCK.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? YES.
(d) Means of injury TRAPPED IN AIR-TIGHT ICE CREAM TRUCK

23. Signature: Robert Le Gaston M.D. Medical Examiner.
Date signed September 19, 1945.

(OVER)

G32571 HOWARD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13-B

Registered No. G32571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution Provident Hospital. 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months 19 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 8 N. Mount St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Charles A. Howard.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1945

8. AGE: Years | Months: 8 7 | Days: 18 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Charles Howard.

13. Birthplace Baltimore, Maryland.

MOTHER

14. Maiden Name Doris Brown.

15. Birthplace Baltimore, Maryland.

16 (a) Informant Doris Brown.

(b) Address 8 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location

18 (a) Funeral director Mrs Kate R. Williams

(b) Address 322 N Schroeder St

19 (a) SEP 22 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1945, at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 1945, to 9-20 1945, and that I last saw him alive on 9-19 1945.

Immediate cause of death Tuberculosis, Meningeal

Due to

Due to

Other Conditions Malnutrition, anemia, Bronchitis.

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. W. Pecklinger M.D.

Address 72 N. Mount Date signed 9/22/45

VS 150

M. D. S. 1248-b

GB2572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

GB2572

✓ 48-B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Harlem Ave 16-2 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Rose Ann Marshall

(a) Residence: No. 1305 Harlem Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Vander Marshall

6. DATE OF BIRTH (month, day, year) Feb 17, 1914

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	7	3	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Fayetteville (State or country) North Carolina

FATHER

13. NAME Jack Thomas

14. BIRTHPLACE (city or town) Bennettsville (State or country) South Carolina

MOTHER

15. MAIDEN NAME Grace Campbell

16. BIRTHPLACE (city or town) Bennettsville (State or country) South Carolina

17. INFORMANT Grace Todd

(Address) 1305 Harlem Ave

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Arlington Memorial Date 9 mo 23 da. 1945

19. UNDERTAKER Mrs Katie R. Williams

(Address) 3 [illegible] Schroeder St.

20. FILED 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 20, 1945

22. I HEREBY CERTIFY, That I attended deceased from September 4 1945 to Sept 20 1945

I last saw her alive on September 20 1945 Death is said to have occurred on the date stated above, at 6:35 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of uterus	18 mos

Other contributory causes of importance:

Name of operation Physical Signs & Symptoms Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) John E. L. Campbell M.D.

(Address) 630 N. Carey St, Balto

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

632573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632573

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Millers
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby ~~Miller~~ Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Univ. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Roth
13. Birthplace Maryland

MOTHER
14. Maiden Name Pauline Miller Roth
15. Birthplace Maryland

16 (a) Informant Jacob Wink Sons
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept 22 45 (month) (day) (year)
(c) Cemetery or crematory Millers
Location Millers Md

18 (a) Funeral director Jacob Winks Sons
(b) Address Manchester Md

19 (a) SEP 22 1945 (Date rec'd by registrar) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1945 at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 9-21 1945 and that I last saw h/ alive on 9-21 1945

Immediate cause of death Resperatory failure

Due to Massive atelectasis

Due to Maternal toxemia before birth & therapy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R B Norment M.D. M. D.
Address Univ. Hosp Date signed 9-22-45

VS 150

G32574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32574 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert Co
(c) City or town Owings, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Marion King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Bertie Pratt King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace Owings, Calvert Co, Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Wm King
13. Birthplace Md

MOTHER
14. Maiden Name Cora Wilkinson
15. Birthplace Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 45 (month) (day) (year)
(c) Cemetery or crematory Mt Harmony
Location Calvert Co Md.

18 (a) Funeral director J. B. Hutchins
(b) Address Owings

19 (a) SEP 22 1945 (Date rec'd by registrar) (b) Huntingtown Md (Signature)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Sept 21 1945. and that I last saw h.im. alive on Sept. 21 1945.

Immediate cause of death Respiratory paralysis — Duration 1 day

Due to Acute (pulbar) Anterior Poliomyelitis — Duration 3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp Date signed 9/24/45

G325?5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G325?5

Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 605 No. Central Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d

(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 605 No. Central Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle French

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife William French

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day hr.	min.
77	?	?		

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Josiah Gross

FATHER 13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Susan

MOTHER 15. Birthplace ?

16 (a) Informant William French

(b) Address 605 No. Central ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Nolan

(b) Address 1000 Brandt & Leyan

19 (a) (Date rec'd by registrar) (b) Huntington White (Registrar)

SEE

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1945 at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1945 to Sept. 17 19 45 and that I last saw her alive on Sept 17 19 45

Immediate cause of death Lobar Pneumonia — Duration 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Ronald Blighton M. D.

Address 501 Cherry Hill Rd Date signed 9/18/45

G32576

AB-93943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G32576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 19-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos- 19days

(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 519 N. Mount St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James B. Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8- 1923

8. AGE: Years	Months	Days	If less than one day
22	2	12	hr. min.

9. Birthplace Turbow, N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Beth-Fairfield-Fairfield, Md.

FATHER

12. Name James Benjamin Wilkins

13. Birthplace N.C.

MOTHER

14. Maiden Name Dorothy Autroy

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave

19 (a) SEP 22 1945 (Date rec'd by registrar) (b) Turbeville, S.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-20- 19 45 at 7.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31- 19 45 to 9-20 19 45 and that I last saw h im alive on 9-20 19 45

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert B. Copeland M. D.

Address Balto. City Hosp. Date signed 9/24/45

VS 150

G32577 FINCH G32577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 A

Registered No. G32577

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State ~~Maryland~~ North Carolina (b) County Vance
(c) City or town Henderson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Finch

3 (b) If veteran, name war W | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1910

8. AGE: Years 34 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Vance Co N C (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Merchant Manager

FATHER 12. Name Sterling W Finch

13. Birthplace N C

MOTHER 14. Maiden Name Bessie L Rowe

15. Birthplace N C

16 (a) Informant James E Finch

(b) Address Henderson N C

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)

(c) Cemetery or crematory Oxford Memorial

Location Vance Co N C

18 (a) Funeral director Williams & Lyon

(b) Address 217 E Front St

19 (a) 9 29 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26th 1945, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Concussion of Brain;
Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept 26 1945 11 A M. 2-3

(b) Where did injury occur? Hotel at Broadway & Lemon St

(c) Did injury occur at home, on farm, industrial place or in public place? Hotel While at work? No

(d) Means of injury Fall to floor

23. Signature Robert Lee Gentry M.D. Medical Examiner.

Date signed 9-22-45

VS 151

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

G32578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 93 D

G32578
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE Carroll
(c) City or town WESTMINISTER (RURAL)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 BOND ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ORPHA SHAW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife 0.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 1862

8. AGE: Years	Months	Days	If less than one day
82	10		hr. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name GEORGE SNYDER
13. Birthplace 0?

MOTHER
14. Maiden Name REBECCA BLACKSTONE
15. Birthplace 0?

16 (a) Informant Hospital records.
(b) Address

17 (a) Burial (b) Date thereof Sept 25 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pipe Creek Church Cem.
Location near Westminster, Md.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster, Md.

19 (a) SEP 23 1945 (b)
(Date rec'd by reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 22 1945, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 19 1945 to SEPT 22 1945, and that I last saw her alive on SEPT 22 1945.

Immediate cause of death	Duration
CORONARY OCCLUSION	
Due to HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
Due to	
Other Conditions PULMONARY EDEMA BRONCHOPNEUMONIA	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CORONARY OCCLUSION MYOCARDIAL INFARCTION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 9-22-45

VS 190

632579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632579

186 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Elizabeth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Park St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gilbert Dickson

3 (b) If veteran, name war

3 (c) Social Security Account No. 194-07-9973

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Marian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4. 1891

8. AGE: Years	Months	Days	If less than one day
54	8	17	hr. min.

9. Birthplace Gettysburg Pa.
(Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER 12. Name Jas Watson Dickson

13. Birthplace Pa.

MOTHER 14. Maiden Name Cly Gilbert

15. Birthplace Pa.

16 (a) Informant Marian Dickson

(b) Address Elizabethtown Pa.

17 (a) Burial (b) Date thereof Sept 24 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Elizabethtown

Location Elizabethtown Pa

18 (a) Funeral director John L. Wolfe

(b) Address 235 E Jefferson

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

SEP 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1945, at 7:55 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Sept 19, 1945 M.

(b) Where did injury occur? Laurel, Md

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Fell from Rostrum Grandstand.

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed 9-21-45

G32580

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 124B

Registered No. G32580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6714 Richardson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Annie Elizabeth Schuyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John H. Schuyler
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) September 5, 1881

8. AGE: Years	Months	Days	If less than one day
64	0	16	hr. min.

9. Birthplace Woodlawn, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Shrevette
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Augusta Perrigo
15. Birthplace Maryland

16 (a) Informant Mrs. Geraldine Scott
(b) Address 6716 Richardson Ave., Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miller L. Corcoran
(b) Address 4510 Liberty Heights Ave.

19 (a) 9/24/1945 (Date received by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1945, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1945 to 9/21 1945, and that I last saw her alive on 9/21 1945.

Immediate cause of death: Toxic Hepatitis
Cellulitis in Ant. Abd. Wall.
Due to Bladder perforation

Due to

Other Conditions Cirrhosis of liver (old)
(Include pregnancy within 3 months of death)

Date of operation 9/8/45

Major findings of operation: Cystocele, Rectocele

of autopsy: Cirrhosis of Liver, Cellulitis in Ant. Abd. Wall.

Duration
9 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Norton, Jr. M. D.
Address Bon Secours Hosp. Date signed 9/21/45

G32581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

G32581
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Lincoln Res —
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas James Truett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1874

8. AGE: Years	Months	Days	If less than one day
71	5	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Prop - Truett Monuments
11. Industry or business Sales

FATHER
12. Name Phillip Truett
13. Birthplace Del

MOTHER
14. Maiden Name Eleanor A. Vincent
15. Birthplace Md.

16 (a) Informant Mrs. Thomas J. Truett
(b) Address Salisbury, Md.

17 (a) Burial (b) Date thereof 9/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parsons
Location Salisbury

18 (a) Funeral director Tilly & Taylor
(b) Address 403 S. Wolfe St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1945 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1945 to 9/22 1945 and that I last saw h[illegible] alive on 9/22 1945.

	Duration
Immediate cause of death: Pulmonary Edema	12 hrs.
Due to: Cardiac decompensation	12 hrs.
Due to: Arteriosclerotic Heart Disease	20 yrs.
Other Conditions: Uremia, Hypertension	

(Include pregnancy within 3 months of death)

Date of operation 9/18/45
Major findings of operation: Adenocarcinoma of prostate.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Chesnin
Address Lincoln Hospital, Baltimore Date signed 9/22/45
M. D.

VS 150

G32582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32582 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Olif Floyd -

3 (b) If veteran, name war

3 (c) Social Security Account No. 708-09-6476

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 - 1893

8. AGE: Years	Months	Days	If less than one day
52	0	11	hr. min.

9. Birthplace Queen Anne Co. Md.
(Town, county, and state)

10. Usual Occupation Boiler maker

11. Industry or business B & O R.R. Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Lillian C. Rahm
15. Birthplace Balto. Md.

16 (a) Informant Lorna H. Floyd
(b) Address 832 Wash. Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2333 Wash Blvd

19 (a) 9-23-1945 (Date rec'd by registrar) (b) Huntington Mitchell, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1945, at 8:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 9-27-45

VS 151

G32583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

74a

G32583 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4634 York Road
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4634 York Road
(If rural, give location)
(e) Citizen of foreign country? ----- (Yes or No)
If yes, name country -----

3 (a) FULL NAME Alice Clara Whittle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William A. Whittle
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	26	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --------

FATHER
12. Name Albert Krager
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Alice Crowley
15. Birthplace Baltimore, Maryland

16 (a) Informant William A. Whittle
(b) Address 4634 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) Huntington Williams M.D. (Registrar)
(b) [illegible] (Registrar)

SEP 27 1945

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1945 at 5:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945 to Sept. 21 1945
and that I last saw h[illegible] alive on Sept. 21 1945.

Immediate cause of death — Duration
Myocardial Insufficiency 6/45-9/45
Due to
Due to
Other Conditions Myocardial Insufficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Linton Reynolds M. D.
Address Temple Gardens Apts. Date signed 9/27/45

G32584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 A

G32584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town) 6
(d) Street No. 2100 N Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Jordan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Cora Jordan
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/22/68

8. AGE: Years 77 | Months 7 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Alex. Jordan
13. Birthplace Ala.

MOTHER 14. Maiden Name Eliz. Stringer
15. Birthplace Ala

16 (a) Informant Records
(b) Address Mercy Hospital

17 (a) Removal (b) Date thereof 9/23/45 (month) (day) (year)
(c) Cemetery Evergreen
Location Elba, Alabama

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (a) 9/24/1945 (b) ... (Date received by registrar) Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1945, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945 to 9/22 1945 and that I last saw h[illegible] alive on 9/22 1945

Immediate cause of death Pneumonitis — Duration ...

Due to Bronchoesophageal Fistula

Due to Carcinoma of esophagus or bronchi

Other Conditions Cardiac Decompensation moderate
(Include pregnancy within 3 months of death)

Date of operation 9/14/45

Major findings of operation: Palliative Procedure Gastrostomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Tully Jr. M.D.
Address Mercy Date signed 9/22

X

G32585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1572E

Registered No. G32585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits write RURAL and give name)
(d) Street No. 8026 Old Philadelphia Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlene Bamford

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 31, 1945
8. AGE: Years | Months | Days: 22 | If less than one day: hr. min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: David T Bamford
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Margaret Kador
15. Birthplace: Baltimore Md

16 (a) Informant: Margt. A. Bamford
(b) Address: 8026 Old Phila Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 25 45 (month) (day) (year)
(c) Cemetery or crematory: Green Lawn
Location: Golden Lane Md

18 (a) Funeral director: Philpott & Son Inc
(b) Address: 1219 E Fayette St

1945 SEP 24 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1945 to 9/23 1945 and that I last saw h[illegible] alive on 9/23 1945.

	Duration
Immediate cause of death: Cardiac Failure	72 hours
Due to: Congenital Heart Disease	3 weeks
Due to:	
Other Conditions: Bronchopneumonia (Include pregnancy within 3 months of death)	48 hours

Date of operation:
Major findings of operation:
of autopsy: Congenital Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Herbert Chernin M.D.
Address: Sinai Hospital Date signed 9/23/45

VS 150

G32586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634 Registered No. G32586

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 263 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence O'Bannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Del. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant L. Davis
(b) Address Washington DC

17. Buried (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Lodge Inc
(b) Address 1217 E. Fayette St.

SEP 24 1945 (Date rec'd by registrar)
(b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1945, at 9:55 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 17, 1945
(b) Where did injury occur? 263 S. Conkling St.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? ho.
(d) Means of injury Inhalation of illuminating Gas

23. Signature Robert L. Traitor M.D. Medical Examiner.
Date signed 9-17-45

E 27 X

G32587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G32587

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Eastern ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME RAY EARL MURRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 - 1899

8. AGE: Years	Months	Days	If less than one day
46	4	9	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Railroad trackman

11. Industry or business

FATHER
12. Name Charles Murray
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rose E. Faust
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)

(c) Cemetery or crematory
Location Scottsdale Pa.

18 (a) Funeral director Alder Funeral Home Inc
(b) Address 4444 York Rd.

19 (a) (Date received by registrar) SEP 24 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1945, to Sept 22, 1945, and that I last saw h-im alive on Sept 22, 1945.

	Duration
Immediate cause of death aspiration of stomach contents into lungs	5 min
Due to Gastric resection	1 hr.
Due to Carcinoma of stomach	3 mo+
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 22, 1945

Major findings of operation: Carcinoma of pylorus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
Address 142 E. Eager St. Date signed 9/22/45 M. D.

G32588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1572

G32588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma Leblond.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-11-45

8. AGE: Years	Months	Days	If less than one day
0		4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Leblond.
13. Birthplace

MOTHER
14. Maiden Name Lula Solmon
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 22 1945

18 (a) Funeral director
(b) Address

SEP 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. Commissioner of Health

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sept. 15 1945, at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Sept. 15 1945 and that I last saw her alive on Sept. 15 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions Congenital Heart Disease, ? Septicemia (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair Everett Bation, M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 9/17/45

VS 150

F 2976 159

G32589

HEALTH DEPARTMENT—CITY OF BALTIMORE

G32589

CERTIFICATE OF DEATH

1310

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Division St. St., 3 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Betty Blackwell 74

If U. S. Veteran specify WAR

(a) Residence: No. 2016 Division St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	Colored	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Blackwell

6. DATE OF BIRTH (month, day, year) Nov 16, 1882

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Va

FATHER

13. NAME —

14. BIRTHPLACE (city or town) (State or country) —

MOTHER

15. MAIDEN NAME Dorothy Johnson

16. BIRTHPLACE (city or town) (State or country) Va

17. INFORMANT Harvey Blackwell

(Address) 2016 Division st

18. BURIAL, CREMATION, OR REMOVAL

Place Arlington Date 9-26 1945

19. UNDERTAKER George S. Wilson

(Address) 1303 Pennsylvania Ave

20. FILED SEP 24 1945 Huntington Williams M.R. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 21, 1945

22. I HEREBY CERTIFY, That I attended deceased from 9-3-45, 19, to 9-21, 1945

I last saw h alive on 9-21, 1945. Death is said to have occurred on the date stated above, at 5½ m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio-Vascular Renal Disease	
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. B. Sutter M. D.

(Address) 2033 Eutaw Place

X 1

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied.

G32590 G32590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE REGISTERED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Brookfield Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Babette K. Rufin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Ben Rufin

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Oct 13 1913

8. AGE: Years 29 | Months 11 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David Kaufman

13. Birthplace Balto Md

MOTHER 14. Maiden Name Bertha Kopito

15. Birthplace Balto Md

16 (a) Informant Evelyn Kaufman

(b) Address 2202 Brookfield Ave

17 (a) Burial (b) Date thereof SEP 25 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sharp Hamden Memorial

Location Balto & Frederick Sts

18 (a) Funeral director Albert Ag

(b) Address 2103 Reisterstown Rd

19 (a) SEP 24 1945 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945, at 10-10 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Sept 23 1945, and that I last saw h[illegible] alive on 9/23 1945.

Immediate cause of death Cardio respiratory failure

Due to Adeno carcinoma of kidney

Due to Marked liver metastasis
Marked Abdominal metastasis

Other Conditions Malnutrition
Avitaminosis
(Include pregnancy within 3 months of death)

Duration

Date of operation 1941 - Nephrectomy

Major findings of operation: Papillary adeno Ca of Kidney

of autopsy: Confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature Louis Applefeld M.D.
Address 2511 Reisterstown Rd Date signed 9/25/45

G32591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4414 Massachusetts Ave

(c) Hospital or institution: 4214 — 28

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4414 Massachusetts Ave (If rural give location)

(e) Citizen of foreign country? — (Yes or No)

If yes, name country —

3 (a) FULL NAME Mary E. Healey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/1879

8. AGE: Years 65 | Months 10 | Days 27 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Retired School Teacher

11. Industry or business Baltimore City

FATHER 12. Name Henry J. Healey

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Elizabeth J. Schnepfe

15. Birthplace Baltimore, Md

16 (a) Informant Anna Healey

(b) Address Massachusetts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month, day, year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director F. D. Waltemeyer Inc

(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 24 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1945; at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1931, to 9-20 1945, and that I last saw her alive on 9-25 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	14 yrs
Due to High Blood Pressure	15 "
Due to Arterio-Sclerosis	15 "
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation — None

Major findings of operation: —

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. Lloyd Johnson M.D.

Address Catonsville Md Date signed 9/22/45

G32592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X940 G32592 Registered No.

S/S Thos. W. Johnson

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md.
(b) Street address
(c) Hospital or Institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) L.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La. (b) County
(c) City or town New Orleans
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3600 Delgado Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Robertson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 464-09-4748

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 23-1891

8. AGE: Years 54 | Months 6 | Days — | If less than one day hr. min.

9. Birthplace Miss. (Town, county and state)

Second Cook on S/S Thos. W. Johnson

10. Usual Occupation Shipping Adm.

11. Industry or business Pountree Co. Inc. Gen. Agts.

FATHER
12. Name James Robertson
13. Birthplace Liverpool Eng.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Leona Roache
(b) Address New Orleans, La.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)

(c) Cemetery or crematory
Location New Orleans, La.

18 (a) Funeral director Stewart & Jones Co.
(b) Address 108 N. North Avenue

19 (a) SEP 24 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1945, at 9:06 A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Coronary Disease.

Due to

Other Conditions Generalized Arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Wheeler M.D.
Medical Examiner.
Date signed September 23, 1945.

(over)

G32593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32593 Registered No. 1192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSONS RESPONSIBLE FOR BURIAL

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun.
(c) Hospital or institution: Franklin Square Hospital 14 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 108 N. Mallory
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fayette and Calhoun.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lee (Burnett Lee)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: Chinese
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept. 7. 1945
8. AGE: Years | Months | Days 14 | If less than one day X hr. 4 min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Lee.
13. Birthplace San Francisco.

MOTHER
14. Maiden Name Anna May Lee
15. Birthplace Baltimore

16 (a) Informant Hosp. Records
(b) Address (Robt Lee (father) 108 W. Mulberry St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- -45 (month) (day) (year)
(c) Cemetery or crematory Loraine Cemetery
Location Woodlawn, Md
18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 108 W. NORTH AVENUE
19 SEP 24 1945 (Date rec'd by registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1945 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 7 1945 to Sep 21, 1945, and that I last saw h alive on Sep 21 1945.

Immediate cause of death Acute Enteritis

Due to Vomiting

Due to Dehydration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. K. Kerzner M. D.
Address Franklin Square Hospital signed 9-22-45

G32594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G32594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORY RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Bolton St.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ethel Todd
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 7/26/72

8. AGE: Years	Months	Days	If less than one day
73	1	25	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Builder
11. Industry or business

FATHER
12. Name John Walsh
13. Birthplace ?

MOTHER
14. Maiden Name Mary Jane Pardon
15. Birthplace ?

16 (a) Informant Mrs. Ethel Todd Walsh
(b) Address 1508 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemy.
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date received by Local Registrar SEP 24 1945 (b) Huntington Nitt

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1945 to Sept 21 1945, and that I last saw him alive on Sept 21 1945.

Immediate cause of death Cerebral Hemorrhage - Paralysis of left side -
Due to Arterial Hypertension and Sclerosis
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

Duration: Sept 18/45 3 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irma F. Krumbein M. D.
Address 722 N. Kenwood Ave. Date signed

VS 150

Dr. Krumbein X Sept 22/45

G32595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G32595

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Taplow Rd. Homeland (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NELLY SUE SPENCE

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John M. Spence, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	29	hr. min.

9. Birthplace Virginia (Richmond) (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER
12. Name Edward C. Gannin
13. Birthplace Virginia (Portsmouth)

MOTHER
14. Maiden Name Endora Walden
15. Birthplace Virginia

16 (a) Informant Mrs. John M. Spence, (Husband)
(b) Address 305 Taplow Rd. Homeland 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 SEP 24 1945 (Date rec'd by Registrar) (b) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1945, at 11.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Sept 22 1945, and that I last saw h alive on Sept. 22 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	2½ days
Due to Generalized arteriosclerosis	
Due to Hypertensive cardiovascular disease	
Other Conditions Arteriosclerotic cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford W. Kalfas Jr.
Address Union Memorial Hosp. Date signed 9/22/45 M.D.

VS 180

632596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632596

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 S. Ellwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM H. KRATZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edwina V. Kratz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1887

8. AGE: Years	Months	Days	If less than one day
58	8	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business Self

FATHER
12. Name Herman Kratz
13. Birthplace Germany

MOTHER
14. Maiden Name Florence Beck
15. Birthplace Germany

16 (a) Informant Mrs. Edwina W. Kratz
(b) Address 900 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 24 1945 (Date rec'd by local reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1945, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Sept 22 1945 and that I last saw h[illegible] alive on Sept 22 1945.

Immediate cause of death Hypertensive Cardiovascular Renal Disease, Coronary Thrombosis
Due to Coronary Occlusion

Due to

Other Conditions None.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

Duration
8-14-45
9-1-45
9-22-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Schenck M. D.
Address 842 E. Eutaw Pl. Date signed 9-24-45

VS 150

G32597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

over G32597

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)

(d) Street No. 511 N. Light St.
(If rural give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) FULL NAME (Anna Mae Scroggy Graw) ANNA MAE GRAW

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-24-1909

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Albert H. Graw

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) June 24 1908

8. AGE: Years	Months	Days	If less than one day
45	3	20	hr. min.

9. Birthplace New Jersey (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business Westinghouse Electric Co.

FATHER

12. Name Edward Scroggy

13. Birthplace Marlton, New Jersey

MOTHER

14. Maiden Name Anna Lutz

15. Birthplace Speicher, Switzerland New Jersey

16 (a) Informant Albert H. Graw Mrs. D.R. Carlson

(b) Address Glen Burnie, Maryland Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery

Location Glen Burnie, Maryland

18 (a) Funeral director Thomas W. Singleton

(b) Address Glen Burnie, Md.

(c) SEP 24 1945 Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Sept 24 1945 and that I last saw h[illegible] alive on Sept 24 1945.

	Duration
Immediate cause of death Cardio respiratory failure	
Due to Ruptured appendix & peritonitis.	6 days
Due to	
Other Conditions appendectomy	

(Include pregnancy within 3 months of death)

Date of operation Sept 23, 1945

Major findings of operation: Ruptured appendix

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Milton Linthicum

Address Mercy Hosp. Date signed 9/27/45 (M. D.)

VS 150

G32598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1359

Registered No. G32598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4128 Hamilton Ave -
(c) Hospital or institution:
Mercy Hosp -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min -
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mins -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balt -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4128 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? no - (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Rhodes -

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	- Single -

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-45

8. AGE: Years	Months	Days	If less than one day
15 minutes			hr. 15 min.

9. Birthplace Balt - Md -
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name John J. Rhodes
13. Birthplace

MOTHER
14. Maiden Name Grace Pecker
15. Birthplace Baltimore

16 (a) Informant Mother -
(b) Address same -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Balto Md
18 (a) Funeral director Leonard J Kluck
(b) Address 5305 Harford Rd
19 (a) Date received by Registrar 9-24-1945 (b) Harrington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 19 45 at 5 22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Birth 19 to Death 19, and that I last saw her alive on 9-22 19 46

Immediate cause of death Respiratory failure — Duration
Due to Prematurity 5½ months foetus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William W. Osborne M.D.
Address Mercy Hosp Date signed 9/22/45

G32599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32599
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town Dameron
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME GANT Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1940

8. AGE: Years	Months	Days	If less than one day
5	7	17	hr. min.

9. Birthplace Dameron St Mary's Co.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Edward Gant
13. Birthplace St Mary's Co.

MOTHER
14. Maiden Name Priscilla Walton
15. Birthplace Cincinnati, O

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-45 (month) (day) (year)
(c) Cemetery or crematory
Location Dameron St Mary's Co.

18 (a) Funeral director Pius B Robinson
(b) Address Hamerson Md

19 (a) SEP 24 1945 (Date received by registrar)

VS 3

Huntington Advocate, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945, to 9-22 1945, and that I last saw her alive on 9-22 1945.

Immediate cause of death respiratory obstruction — Duration 2 days
Due to diphtheria — 5 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 9/23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32600 — over — 108 — [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Rayner Ave
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Kathleen' [redacted] Williams

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht.	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1939

8. AGE: Years	Months	Days	If less than one day
5	9	--	..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Woodrow J. Williams
13. Birthplace Alexandria Va.

MOTHER
14. Maiden Name Louise M. Thiel
15. Birthplace Baltimore Md.

16 (a) Informant Woodrow J. Williams
(b) Address 2816 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

SEP 24 1945

Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-45 19..., at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1945, to 9-23 1945, and that I last saw her alive on 9-23 1945

Immediate cause of death Respiratory failure — Duration .....

Due to Cardiac Failure — Duration .....

Due to Severe Pericardial Effusion - Post Pneumonic — Duration .....

Other Conditions — Duration over

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Samuel Ch. Durkee M. D.
Address W. J. Walter Mem. Hospital Date signed 9/23/45

VS 15

G32601

CMK-96196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G32601

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 13 Mos

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1407 Kuper Place

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Slone or Edward Stone (EDWARD SLONE)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1944

8. AGE: Years	Months	Days	If less than one day
1	0	21	hr. min.

9. Birthplace Baltimore-Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Slone or Stone

13. Birthplace Kentucky

MOTHER 14. Maiden Name Marie Poff

15. Birthplace Kentucky

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto City

18 (a) Funeral director J. J. B. M. Waltes

(b) Address Pratt & Fulton Sts

19 (a) SEP 24 1945 (Registrar's signature)

Huntington Pittsburgh Md

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sept. 22- 1945 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1945, to Sept. 22 1945, and that I last saw h alive on Sept. 22 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Bronchopneumonia	2 day
Due to	
Other Conditions Osteomyelitis of jaw, otitis media, + dehydration	

(Include pregnancy within 3 months of death) Anuria

Date of operation

Major findings of operation:

of autopsy Bronchopneumonia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. M. Morrison Jr. M. D.

Address City Hospital Date signed 9/24/45

VS 150

G32602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

G32602 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) ~~County~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 W. Eutaw St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Avery Beelaner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
67				

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Haley
13. Birthplace Illinois

MOTHER
14. Maiden Name Mattie Snow
15. Birthplace Illinois

16 (a) Informant Avery Beelaner
(b) Address 507 W. Fredonia St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/23/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Rd.

18 (a) Funeral director M. W. & D. Oppelt Sons
(b) Address Lombard & Gay Sts.

19 (a) SEP 24 1945 (Date rec'd by registrar) Thurlington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/45 19 . at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/21 1945, and that I last saw him alive on 9/21 1945

Immediate cause of death Acute Yellow Atrophy

Due to Hepatitis

Due to Toxic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Toxic hepatitis

Duration
2 weeks
3 weeks
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard T Kurland M. D.
Address University Hosp. Date signed 9/24/45

G32603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G32603

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 W. Clement St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (30) (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 W. Clement St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie Ann Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, ~~divorced~~: Widowed

6 (b) Name of husband or wife (deceased): Levering C. Myers | 6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1879

8. AGE: Years 66 | Months 6 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Mt. Airy, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER — 12. Name Don't Know
FATHER — 13. Birthplace Md

MOTHER — 14. Maiden Name Don't Know
MOTHER — 15. Birthplace Md.

16 (a) Informant Robt. E. Lee Myers (Son)
(b) Address 5 W. Clement St., Balto. 30, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25-1945 (Month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Ga. Co., Md.

18 (a) Funeral director P. Bernard Evans
(b) Address 7400 S. Charles St, Balto. 30, Md.

19 SEP 24 1945 (Date rec'd by local reg.) (b) Huntington Williams M.D. (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23, 1945 at 12:35 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9/ 1944 to 9/23/ 1945 and that I last saw her alive on 9/23/ 1945.

Immediate cause of death: Coronary thrombosis — Duration: 9 mos.

Due to:

Due to:

Other Conditions: Hypertensive cardio vascular disease — ?
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiler M.D.
Address 1226 Hanover St Date signed 9/24/ 1945

VS 150

G32604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

G32604

Registered No. .....

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Pierce St.
(c) Hospital or institution:

1811

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Pierce St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME John Baldwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Unknown

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/30/1871

8. AGE: Years	Months	Days	If less than one day
74	4	21	..... hr. ..... min.

9. Birthplace Ala.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Dept. of Public Welfare
(b) Address 327 St. Paul Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles H. Cooper
(b) Address 512 N. Carrollton Ave

19 SEP 24 1945 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/45 19.... at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-45 19.... to 9-20-1945
and that I last saw h im alive on 9-20-1945.

Immediate cause of death Cerebral Hemmorhage

Due to Hypertension

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration
.....
.....
.....
.....
.....
.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature R K Johnson M. D.
Address 600 N Carrollton Ave Date signed 9-24-45

G32605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G32605
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 S.EAST AVE.
(c) Hospital or institution: 26 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S.EAST AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL BENKE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife THERESA BENKE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.22 1879

8. AGE: Years	Months	Days	If less than one day
66	8	21	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation DRILLER
11. Industry or business SPARROWS POINT

FATHER
12. Name JOHN BENKE
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant THERESA BENKE (WIFE)
(b) Address 820 S.EAST AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT.25/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 S.WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 24 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT.21 1945 at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1937 to Sept 21 1945, and that I last saw h alive on Sept 21 1945.

	Duration
Immediate cause of death Hypertensive C.V. Disease Cerebral Hemorrhage	8-1-37
Cerebral Hemorrhage	2-4-45
Due to Ruptured Embolus	9-17-45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eg Schumacher M. D.
Address 842 Eastern Date signed 9-22-45

G32606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119 A

G32606

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 15 d.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt.

(c) City or town Baltimore, Md.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2207 Parnasso Ave.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Edward M. Jeffers, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	14 15	10 hr. min.

9. Birthplace West Balt. General Hosp.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edward M. Jeffers

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Caroline Ackerman

15. Birthplace Baltimore, Md.

16 (a) Informant Father

(b) Address 2207 Parnasso Ave.

17 (a) Burial (b) Date thereof 9-25-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon PARK

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Weitzke

(b) Address 4101 Edmondson Ave

19 (a) (b)

(Date rec'd by Registrar) Registrar

SEP 24 1945

VS 600 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1945, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945, to 9-23 1945, and that I last saw him alive on 9-23 1945.

Immediate cause of death Accidents

Duration

Due to Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(c) Means of injury

23. Signature J. B. Davey M. D.

Address Univ. Hosp. Date signed 9-23-45

G32607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32607 Registered No. 48 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sevell Apts
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Sevell Apts Lake Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Kolodny

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
61				

9. Birthplace Russia (town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Samuel Silverstein
13. Birthplace Russia

MOTHER
14. Maiden Name Barbara
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-40 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore Cordley Sts

18 (a) Funeral director Jack Levine
(b) Address 2400 Eutaw Place

19 (a) (b) Registrar
Date received by registrar SEP 24 1940
VS Rec

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21- 1940, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on Sept 21 19 40.

Immediate cause of death Cardiac failure — Duration 3 days

Due to Arteriosclerotic, Cancer ovar — Duration about 1 year

Due to — Duration over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred Weinman
Address 1712 Eutaw Place Date signed 9-24-40 M. D.

Huntington Williams, M.D.

X

G32608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √55B

Registered No. G32608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1005 Valley St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1005 Valley St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert W. Raine

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 219-01-0474

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie A. Allen Raine

6 (c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.) Aug. 31. 1876

8. AGE: Years 69 | Months 0 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Night Watchman

11. Industry or business Shipping Miller

FATHER

12. Name Albert E. Raine

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Wilmine Rath

15. Birthplace Germany

16 (a) Informant Mrs Sadie A. Raine

(b) Address 1005 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25/45 (month) (day) (year)

(c) Cemetery or crematory Bl. John's Cemetery

Location Long Green Md.

18 (a) Funeral director Elmer W. Conkle Son

(b) Address 92 E. Eager St.

19 (a) Date received by registrar SEP 24 1945 (b) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22. 1945 at a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13th 1945 to Sept 10 1945 and that I last saw him alive on Sept 10th 1945.

Immediate cause of death Generalized metastases of Bone Tumor — Duration 2 years

Due to Bone-Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Karl Traugott M. D.

Address 11 E Chase St Date signed 9-21-45

Karl Traugott

G32609

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

G32609
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 N. Bradford St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 D
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 N. Bradford (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Hicks Mills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	married

6 (b) Name of husband or wife Herbert Mills
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1905

8. AGE: Years	Months	Days	If less than one day
40	6	22	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Allie Glasco
13. Birthplace Unknown

MOTHER
14. Maiden Name Bessie Thompson
15. Birthplace Unknown

16 (a) Informant Herbert Mills
(b) Address 202 N Bradford St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Arbutus Memorial Pk
Location Baltimore Co

18 (a) Funeral director J. D. Preston Funeral
(b) Address 519 Mosher St

19 (a) (Date received by registrar) (b) Huntington Williamsport, Md

SEP 24 1945
VS-1a

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Sept 24 1945
and that I last saw h alive on Sept 21 1945

Immediate cause of death Carcinoma of Rectum — Duration 14 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rose O. Johnson, M.D.
Address 2829 Guilford Ave Date signed Sept 25 1945

G32610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

143A

Registered No. G32610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 or Becket St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Valie Fair + mary alice Fair 523142

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	married

6 (b) Name of husband or wife George Washington Fair
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Dec. 25 - 1918

8. AGE: Years	Months	Days	If less than one day
26	8	25	hr. min.

9. Birthplace Baltimore City, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Edward Guttridge
13. Birthplace Virginia

MOTHER
14. Maiden Name Trainor
15. Birthplace Maryland.

16 (a) Informant George Washington Fair
(b) Address 1706 N Becket St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Delph Rd

18 (a) Funeral director Blaine + Hoffman
(b) Address 1639 N Broadway

19 (a) SEP 29 1945 (Date rec'd by Registrar) (b) Huntingtown Williams, Md. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/ 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1945, to 9/22 1945, and that I last saw her alive on 9/22 1945.

Immediate cause of death Respiratory & Cardiac failure — Duration 17 days

Due to Anaemia a) Cerebral b) Generalized — Duration 1 year

Due to Severe Hemmorrhage + shock — Duration 4 days

Other Conditions Pregnancy + Placenta Previa Centralis — Duration 9 mos.
(Include pregnancy within 3 months of death)

Date of operation 9/21/45

Major findings of operation: Placenta Previas Centralis

of autopsy: none granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A Braun-Kelly M. D.
Address University Hosp. Date signed 9/22/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

183

G32611

Registered No. Series A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. S/S Dunkelon
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aran H. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 9-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lowans
Location Bellona

18 (a) Funeral director Oder Funeral Home Inc
(b) Address 6644 York Rd

SEP 24 1945
(Date rec'd by registrar) Washington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1945, at 4:35 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-20-45 at 4:30 P. M. (Found)
(b) Where did injury occur? Pier #3, Canton, Harbor
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work?
(d) Means of injury Found Drowned.

23. Signature Howard J. Claussen M.D.
Medical Examiner.
Date signed September 21, 1945.

G32612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

196 A

G32612

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Steeg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) [illegible]mant
(b) [illegible]dress

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)

(c) Cemetery or crematory Lovans
Location Bellona Ave

18 (a) Funeral director Ober Funeral Home Inc
(b) Address 7647 York Rd

19 (a) (Date received) (b) Thurlington Williams M.D. (Registrar)

SEP 24 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23- 1945 at 5:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-22- at 2 a.m.
(b) Where did injury occur? S/S Solomon June
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Fell down hatch, about ship.

23. Signature Howard J. Mendeis M.D.
Medical Examiner.

Date signed 9-24-45

Special Agent [illegible]
Boston & Maine [illegible]

CORRECTIONS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G32613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Eareckson Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Eareckson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Dimpert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles Dimpert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 - 1862

8. AGE: Years	Months	Days	If less than one day
83	—	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Conrad Simon
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth —
15. Birthplace Germany

16 (a) Informant Miss Catherine Dimpert
(b) Address 1616 Eareckson Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Rd. 14
(c) Date rec'd by registrar 1945 (Christopher Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1 1945 to Sept 19 1945, and that I last saw her alive on Sept 18 1945

Immediate cause of death Carcinoma of Stomach — Duration 1 yr.
Due to Chronic Exhaustion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Gomy M.D.
Address 6777 Rosedale Date signed 9/21/45

VS 150

Dr. Jos. Sedlacek
503 West Chesapeake Ave.
Towson-4-Maryland

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32614
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Northwick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Northwick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Florence Sheedy

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-1518

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1914

8. AGE: Years	Months	Days	If less than one day
30	9	13	hr. min.

9. Birthplace Detroit, Michigan
(Town, county, and state)

10. Usual Occupation Print Oerator

11. Industry or business Eastern Aircraft

FATHER
12. Name Maurice J. Sheedy
13. Birthplace Illinois

MOTHER
14. Maiden Name Catherine Gilbert
15. Birthplace Ohio

16 (a) Informant Mrs. Katherine Holmes
(b) Address 1021 Northwick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- -45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer 9-26-45
Location Baltimore Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 1945 (b) rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1945 at 2 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to Sept 1945
and that I last saw her alive on Sept 22 1945

Immediate cause of death Intra cardiac Embolism — Duration —

Due to Auricular Fibrillation Angina? —

Due to Rheumatic Heart Disease ? —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. F. Sedlacek M. D.
Address Towson Md Date signed 9/24/45

VS 150 Huntington Williams, MD

Sedlacek

G32615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G32615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 W. Hamburg St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 W. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-1917

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Albert W. Smith
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) October 14, 1860

8. AGE: Years	Months	Days	If less than one day
64	11	10	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)
10. Usual Occupation Tipper
11. Industry or business Umbrella Factory

FATHER
12. Name George E. Pardoe
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Sarah Brady
15. Birthplace Calvert County, Md.

16 (a) Informant Mrs. Wm. H. Bennett
(b) Address 609 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Lamonaw
(b) Address 4520 Liberty Heights Ave.

19 (a) SEP 24 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1945, at 2.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Sept 24 1945. and that I last saw her alive on Sept 24 1945.

Immediate cause of death Myocarditis — Duration 12 days
Due to
Due to Cardiac Dilitation
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Morley Stone M. D.
Address 729 Washington Blvd Date signed

G32616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32616 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 E J. Monroe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E J. Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph John Eisel

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-2673

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May [illegible] 5

8. AGE: Years about 64 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Meat Packer

11. Industry or business Mitchell & Co.

FATHER
12. Name Nicholas Eisel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Dahnhof
15. Birthplace Baltimore

16 (a) Informant Mrs Jos P Eisel
(b) Address 604 E Fairmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Loudon Highway

18 (a) Funeral director John J. Flaherty Sons
(b) Address 1318 Eutaw St.

19 (a) SEP 24 1945 (Date rec'd by registrar) (b) [illegible]
Thornton for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1945, at 6 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1945 to Sept 22 1945.
and that I last saw h[illegible] alive on Sept 22 1945.

Immediate cause of death Coronary Occlusion — Duration 1 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1279 Hilton Date signed 9/24/45

VS 150

(1) G32617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

G32617 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 436 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Ann Von Holten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife Charles Von Holten.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/17/62

8. AGE: Years	Months	Days	If less than one day
4 V 43	10	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Matthew Kavanaugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Murtaugh
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Drinkman
(b) Address 436 E Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto. Md.

18 (a) Funeral director Mary M Wiedefeld
(b) Address 21 E. 2nd St.

19 (a) 9/25/1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1945, at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1945 to 9/21 1945 and that I last saw her alive on 9/21 1945

Immediate cause of death Cardio Respiratory Failure — Duration

Due to Generalized Carcinomatosis

Due to Site Undetermined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca. - liver; lungs; mesentery

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J. Everett M. D.
Address St. Joseph's Hosp. Date signed 9/21/45

VS 190

G32618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/2

Registered No. G32618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3904 Green Spring Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3904 Green Spring Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Rosina Mazula

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Alessi Mazula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1869

8. AGE: Years	Months	Days	If less than one day
76	7	0	hr. min.

9. Birthplace Cosenza, Italy

(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Frank Bevagua

13. Birthplace Italy

MOTHER 14. Maiden Name Teresa Nocito

15. Birthplace Italy

16 (a) Informant Teresa M. Hauck

(b) Address 104 Tuscany Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1847 St. Paul St.

SEP 25 1945

(Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22nd 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1926 to 9-22 1945, and that I last saw h[illegible] alive on 9-22 1945

Immediate cause of death: arterio-Sclerotic heart disease — Duration 1940

Due to arterio Sclerosis — 1939

Due to Chr. nephritis — 1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. A. Michelsen M. D.

Address 2230 Eutaw Pl. Date signed 9/24/45

VS 150

632619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 632619

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Enson St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Enson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary McNulty

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3. 1874

8. AGE: Years 71 | Months 1 | Days 29 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housekeeper Retired
11. Industry or business

FATHER
12. Name Mahonny McNulty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mahonny Dowd
15. Birthplace Ireland

16 (a) Informant Charles L Brooks
(b) Address 1028 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Milburn Cook Inc
(b) Address 1210 E Lond St

SEP 25 1945 (Date received by Registrar) (b) Washington Millspaugh M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1945, to Sept 23 1945, and that I last saw h.. alive on Sept 23 1945.

Immediate cause of death

Duration

Acute Cardiac Dil — 1 day
Due to Hemorrhage & Stomach — ?
Due to Chr. Valv. Heart Dis. — ?
Other Conditions Carcinoma of Stomach.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C V Megee Dr
Address 1520 E 33rd Date signed 9/26/45

92D

Va 150

G32620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1931

Registered No. G32620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or Institution St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 61

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Niebrading
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband Anthony J. Niebrading
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2/16/84
8. AGE: Years 61 Months 7 Days 8 If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business At Home
FATHER 12. Name Jacob Luckert
13. Birthplace Germany
MOTHER 14. Maiden Name Barbara Rebkeal
15. Birthplace Germany
16 (a) Informant George Niebrading
(b) Address 1728 E. Oliver St.
17 (a) Burial (b) Date thereof 9/25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
19 SEP 25 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1945, at 10:20 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1945 to 9/24 1945, and that I last saw h alive on 9/24 1945

	Duration
Immediate cause of death Cardiac ? vascular accident	
Due to Hypertensive cardio vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 9-24-45

VS 150

G32621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1102

Registered No. G32621

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 674 N. Fayette Street
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 674 N. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice M. McConaty

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or ~~divorced~~
Female	White	Married

6 (b) Name of husband William B. McConaty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Lynchburg Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name William R. McCarty
13. Birthplace Lexington Va.

MOTHER
14. Maiden Name Mary Blackburne
15. Birthplace Richmond Va.

16 (a) Informant Mrs Elizabeth Cross
(b) Address 404 Fst. N.E. Washington D.C.

17 (a) Removal (Burial, cremation, or removal)
(b) Date thereof 9/25/45 (month) (day) (year)
(c) Cemetery or crematory Lynchburg
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

SEP 25 1945 (Date rec'd by registrar)
(Signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 1945, at 8 40 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchio-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner
Date signed 9-24-45

VS 151

G32622 D.C. G32157 G32622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 11192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun.
(c) Hospital or institution: Franklin Square Hospital. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State U.S.A. (b) County
(c) City or town 914 Abbott Court Zone A
(if outside city or town limits, write RURAL and give town)
(d) Street No. 914 (if rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Margaret Ann Spring

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white.	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13-45

8. AGE: Years	Months	Days	If less than one day
		10	19 hr. 6 min.

9. Birthplace Baltimore. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER / FATHER

12. Name Kenneth Spring.
13. Birthplace Cumberland Md
14. Maiden Name Emelia E Spring.
15. Birthplace Maryland.

16 (a) Informant Kenneth L Spring
(b) Address 914 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St.

19 SEP 25 1945 (Date received by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 23 1945, and that I last saw him alive on Sept 23 1945.

Immediate cause of death Acute Intestinal Obstruction — Duration

Due to Abdominal.

Due to

Other Conditions

(include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad Gordon M. D.
Address 2201 W. North Ave Date signed 9-23-45

VS 150

G32623

HEP #96071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32623

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 74-0 & 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alverta Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-1871 ?

8. AGE: Years	Months	Days	If less than one day
73 74?	11	10 9	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Eleanor Deale
15. Birthplace Pa

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson Lodge Inc
(b) Address 1214 Light St.

SEP 25 1945 (Date rec'd by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23rd, 1945 at 12:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1945 to Sept. 23, 1945 and that I last saw her alive on Sept. 23, 1945

Immediate cause of death Cerebral Hemorrhage — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral hemorrhage Gen. arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave Date signed 9-24-45

VS 150

G32624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. G32624

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Balto. 7

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1233 N. Washington ST.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. Boykin

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Boykin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24, 1897

8. AGE: Years	Months	Days	If less than one day
47	11	0	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Grassman

13. Birthplace Md

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Marie Jenkins

(b) Address 1832 N Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto - Md

18 (a) Funeral director Tilhom & Son

(b) Address 1219 E Fort Ave

19 SEP 25 1945 Harrington Williams MD

(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1945 at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945 to 9-24 1945, and that I last saw her alive on 9-24 1945.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M C Robertson M. D.

Address St Josephs Hosp Date signed 9-22-45

G32625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G32625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Westfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E Depro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna E Depro

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21. 1889

8. AGE: Years 56 | Months 0 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles A Depro
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna E Albright
15. Birthplace Baltimore, Md

16 (a) Informant Anna E Depro
(b) Address 3200 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilbur Coffroth
(b) Address 1219 Lt St

SEP 25 1945
(Date rec'd by registrar)

(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Sept 22 1945
and that I last saw h alive on Sept 21 1945

Immediate cause of death: Coronary thrombosis — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.

Address 2739 Eastern Ave Date signed 9/24/45

VS 180

G32626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

Registered No. G32626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4825 Oroille Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Eister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 4th 1945

8. AGE: Years | Months | Days: 20/19 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Fred M. Eister
13. Birthplace: Pa.

MOTHER 14. Maiden Name: Kathryn A. Fisher
15. Birthplace: Pa

16 (a) Informant: Fred M. Eister
(b) Address: 4825 Oroille Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9/25/45 (month) (day) (year)

(c) Cemetery or crematory: Westside
Location: Sunbury Pa.

18 (a) Funeral director: William Bok Inc
(b) Address: 1217 St. Paul St.

SEP 25 1945 (Date Received by Registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1945, at 8:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 23 1945, and that I last saw him alive on Sept 23 1945

Immediate cause of death: Diarrhea — Duration: 15 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Coral Gordon M. D.
Address: 2201 W North Ave Date signed: 9-23-45

VS 150

G32627

476142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G32627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Bennett.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-16-95

8. AGE: Years	Months	Days	If less than one day
50	4	8	..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER 12. Name Franklin Bennett
13. Birthplace Md

MOTHER 14. Maiden Name Rydin
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Leerich Funeral Home
(b) Address 208 Orleans St

SEP 25 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945 at 1.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to Sept 24 1945, and that I last saw him alive on Sept 24 1945.

	Duration
Immediate cause of death Cirrhosis of liver & acute hepatic necrosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/20/45
Major findings of operation: Cirrhosis
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Grant Wilson M. D.
Address John Hopkins Hospital Date signed 9/24/45

VS 150

G32628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32628 48 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~Fort & Bouldin Sts~~

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-11

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balt

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 401 S Bouldin (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Hoffmeister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Hoffmeister

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Apr 8 1885

8. AGE: Years	Months	Days	If less than one day
60	5 4	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name John H. Hoffmeister

13. Birthplace Baltimore

MOTHER

14. Maiden Name Elizabeth Zimmerman

15. Birthplace Balto

16 (a) Informant John Hoffmeister

(b) Address 401 S Bouldin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Catonsville

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2005 Reisters St

SEP 25 1945 (Date rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 45, at 7:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1945, to Sept 22 1945, and that I last saw her alive on Sept 22 1945.

Duration

Immediate cause of death Multiple Pulmonary Embolii

Due to CA of fundus uteri

Due to Hypertension & Arterio-sclerotic heart disease. Chronic passive congestion

Other Conditions Probable Subacute endocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: pulmonary embolii

of autopsy: CA of fundus uteri

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arnold Katz M. D.

Address Sinai Hosp Baltimore Md Date signed 9-27-45

VS 150

G32629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940

Registered No. G32629

The correct age is especially important. Physicians; please write the causes of death clearly and legibly. Every item of information should be carefully supplied. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Saffron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Beckie Saffron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Barbelman
11. Industry or business Tailor Shop

FATHER
12. Name Joseph -
13. Birthplace Russia

MOTHER
14. Maiden Name Lilly -
15. Birthplace Russia

16 (a) Informant Beckie Saffron
(b) Address 509 N. Patt. Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)
(c) Cemetery or crematory Adath Israel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

19 (a) [illegible] (Name of registrar) Huntington Williams, M.D.

SEP 25 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945 at 10 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haussis M.D.
Medical Examiner.
Date signed 9-24-45

G32630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G32630 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 W. Hamburg Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 W. Hamburg Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Williams

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-15-1880

8. AGE: Years	Months	Days	If less than one day
65	5	8	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name James Asbury
13. Birthplace Md

MOTHER 14. Maiden Name Harriett Johnson
15. Birthplace Md

16 (a) Informant Richard Johnson
(b) Address 1300 Madison ave

17 (a) Burial (b) Date thereof 9-26-45 (month) (day) (year)
(burial, cremation, or removal)

(c) Cemetery or crematory Mt Moriah Cemetery
Location A. A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (b)
(Signature and title)

SEP 25 1945

Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23- 1945, at 10 50 AM

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cardio-vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 9-23-45

G32631 over G32631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104B

Registered No. .....

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16a
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Central Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME James A. Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/15/42

8. AGE: Years	Months	Days	If less than one day
3	7	5	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation child.

11. Industry or business .....

FATHER
12. Name James A. Lee
13. Birthplace N. C.

MOTHER
14. Maiden Name Lillie Mae Walden
15. Birthplace N. C.

16 (a) Informant Lillie M. Lee
(b) Address 705 N. Central ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location .....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Brentley ave

19 (a) ..... (b) Huntington Williams Registrar
(Date received by Registrar)

SEP 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20-1945, at 9 30 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lateral Sinus Thrombosis of Brain

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert L. Yaskin M.D.
Medical Examiner.
Date signed 9-21-45

G32632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32632 / 46E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 W Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Hartsock

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 - 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
71		29		

9. Birthplace Cooksville Md (city or county, and state)
10. Usual Occupation Retired
11. Industry or business Housewife

FATHER
12. Name Robert L Conaway
13. Birthplace Md Balto Co

MOTHER
14. Maiden Name Rose A. Lemmon
15. Birthplace Cooksville Md

16 (a) Informant Rose Conaway.
(b) Address 2nd Cooksville Md 100 Mile

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26th 45 (month) (day) (year)
(c) Cemetery or crematory Mt Kendrick Cem
Location Carroll Co Md

18 (a) Funeral director Charles J Powell
(b) Address 2427 E Monument Balto

19 (a) SEP 25 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1945, at 9:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1945 to 9-24 1945, and that I last saw h[illegible] alive on 9-24 1945.

Immediate cause of death: Carcinoma of Colon
Carcinomatosis
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)

Duration: 2 yrs?

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jem Ashman M. D.
Address 1201 Poplar Grove St Date signed 9-27-45

G32633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G32633

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie V. Price

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W

6 (b) Name of husband or wife James D. Price
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1859

8. AGE: Years	Months	Days	If less than one day
86	6	2	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16. (a) Informant Mrs. Ragozel Rowan
(b) Address 1602 Webster St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director James L. McCauley
(b) Address 801 Fulton Ave.

19 (a) (Date rec'd by registrar) (b)
SEP 25 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/45 19 , at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/15 1927, to 9/22 1945, and that I last saw h. alive on 9/21 1945.

Immediate cause of death: Hypertension Cardio-Vascular Disease

Duration
3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin B. Jorrell M. D.
Address 11 E. Chase St. Date signed 9/24/45
X City.

G32634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G32634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 Battery Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 Battery Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ada E. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife August Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1893

8. AGE: Years	Months	Days	If less than one day
52	0	0	hr. min.

9. Birthplace Glen Burnie, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George M. Durner
13. Birthplace Md.

MOTHER
14. Maiden Name Laura E. Wade
15. Birthplace Md.

16 (a) Informant August Myers
(b) Address 1437 Battery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director John F. Dysart, Inc.
(b) Address 715 Light St.

SEP 25 1945 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Sept 24 1945, and that I last saw h alive on Sept 24 1945.

Immediate cause of death	Duration
Exhaustion	2 days
Due to Carcinoma of Uterus - Inoperable	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Koch Leonhardt M. D.
Address 1644 Hanover Date signed Sept 24/45

VS 150

G32635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43E

G32635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 Huntington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2828 Huntington Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward F. Hoskall

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-2561

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1906

8. AGE: Years 39 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business Balto Furnit Co

FATHER
12. Name Franklin P. Hoskall
13. Birthplace Maryland.

MOTHER
14. Maiden Name Rachel H. Wilson.
15. Birthplace Maryland.

16 (a) Informant Mrs. Mark S. Miller
(b) Address 2828 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26/45 (month) (day) (year)

(c) Cemetery or crematory Hereford
Location Balto Co, Md

18 (a) Funeral director Rhinowich & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (b) Huntington Hillcrest, Md

SEP 26 1945

VS 151

MEDICAL CERTIFICATION 10, 35

20. DATE OF DEATH September 23, 45 19 , at A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mercer M.D.
Medical Examiner.
Date signed September 24, 1945.

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G32636 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2212 Fleet St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2212 Fleet St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Eva Weinkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick Weinkowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20 1851

8. AGE: Years	Months	Days	If less than one day: hr.	min.
94	5	4		

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER

12. Name Unknown

13. Birthplace

MOTHER

14. Maiden Name Gottlieb Otremba

15. Birthplace Germany

16 (a) Informant Mrs Anna Schaeffer

(b) Address 704 N. Rose St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)

(c) Cemetery or crematory St. Pauls

Location Rendell Ave.

18 (a) Funeral director Wm. C. Miller Inc.

(b) Address 2437 E. Oliver St

19 (a) SEP 25 1945 (Date received by Registrar) (b) Registrar's signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1945 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Sept 23 1945 and that I last saw h[illegible] alive on Sept 23 1945.

Immediate cause of death Pabalrot Hemorrhage — Duration 2 days

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. J. Tankersley M. D.

Address 100 N Milton Date signed 9/27/45

VS 150

G32637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117A

G32637 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Balto., Md.
(b) Street address — 1514 Division St.
(c) Hospital or institution: — Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) — 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md. (b) County
(c) City or town — Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. — 1129 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME — Irving Stafford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex — M

5. Color or race — Negro

6 (a) Single, married, widowed, or divorced. — widower

6 (b) Name of husband or wife — Rosie J. Stafford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 12/21/1895.

8. AGE: Years — 50 | Months — 9 | Days — | If less than one day hr. min. — 49

9. Birthplace — Baltimore, Md. (Town, county and state)

10. Usual Occupation — Chemical Worker

11. Industry or business

FATHER
12. Name — James Stafford.
13. Birthplace — Md..

MOTHER
14. Maiden Name — Sarah
15. Birthplace — Md..

16 (a) Informant — Daisy Brown.
(b) Address — 1129 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — 9-24-45 (month) (day) (year)
(c) Cemetery or crematory — Mt. Auburn
Location

18 (a) Funeral director — Mrs Katie R. Williams
(b) Address — 322 N Schroeder St.

19 (a) (Date rec'd by registrar) (b) — Huntington Williams, M.D.

SEP 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH — 9/21/45 — 1945, at 10:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/45 to 9/21/45, and that I last saw him alive on 9/21/45.

Immediate cause of death — Gastric Ulcer of the penetrating type — Duration

Due to

Due to

Other Conditions — Bilateral inguinal hernias. (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature — James J. Byrne M. D.
Address — 1514 Division Date signed — 9/22/45

632638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

632638 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N Parrish St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Esther Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1924

8. AGE: Years	Months	Days	If less than one day
21	2	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Dishwasher

11. Industry or business

FATHER
12. Name Robert Richardson
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Garland
15. Birthplace S. C.

16 (a) Informant Mother
(b) Address 419 Parrish

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 (a) Registered (b) Registered
SEP 25 1945
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945 at 5-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Sept 21 1945, and that I last saw h alive on Sept 21 1945.

Immediate cause of death	Duration
Meningitis	13 day
Due to Tuberculosis	
Due to	
Other Conditions Miliary tuberculosis (Include pregnancy within 3 months of death)	One

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron B. Tull M. D.
Address Sydenham Hosp Date signed 9/22/45

G32639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32639 Registered No. 93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Cleveland st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Cleveland st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Maxwell

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret A.
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1882

8. AGE: Years	Months	Days	If less than one day
63	5	28	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Horseshoer
11. Industry or business

FATHER
12. Name John T. Maxwell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kate Haller
15. Birthplace Balto. Md.

16 (a) Informant Mrs. M. A. Maxwell
(b) Address 1212 Cleveland st

17 (a) Burial (b) Date thereof 9/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director Krause Funeral Home
(b) Address 1216 N. Charles St.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1945 at 8.06 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1945 to Sept 23 1945 and that I last saw h alive on Sept 23 1945.

Immediate cause of death	Duration
Myocarditis & Cardiac decompensation	3 weeks
Due to Sation	
Due to Multiple arthritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Norris
Address 104 East west st Date signed 9-23-45

VS SEP 25 1945 Huntingtown Williams, M.D.

G32640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G32640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 447 E. 23rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1w
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 447 E. 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wood Dunmore

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Robert Dunmore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1 - 1885

8. AGE: Years	Months	Days	If less than one day
60	5	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name Richard Wood,
13. Birthplace Md,

MOTHER 14. Maiden Name Rebecca Bransford
15. Birthplace Md

16 (a) Informant Robert Dunmore
(b) Address 447 E. 23rd St

17 (a) Burial (b) Date thereof 9-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Memorial
Location Greenmount

18 (a) Funeral director Rayner Sanders
(b) Address 462 E. Preston St

19 SEP 25 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15-45 19 , to 9-21-45 19 , and that I last saw h alive on 9-21-45 19

Immediate cause of death Hypertension Cardiovascular Renal Disease — Duration 2yrs

Due to

Due to

Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Rhoads, M. D.

Address 312 E 23rd St Date signed 9-27-45

X

G32641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 S Monroe st
(c) Hospital or institution:
2023
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 S Monroe st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank B Savonet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Cecelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 18 1873

8. AGE: Years 72 | Months 5 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Frank Savonet
13. Birthplace Austria

MOTHER 14. Maiden Name Josephine Henderson
15. Birthplace Austria

16 (a) Informant Miss Inga Rock
(b) Address 304 S Monroe st

17 (a) Burial (b) Date thereof 9-26-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) SEP 25 1945 (b) Registered No.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 24 1945, at 9:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 19__, to SEPT. 24 1945, and that I last saw him alive on SEPT. 24 1945

Immediate cause of death	Duration
BRONCHIAL ASTHMA	(?)
MYOCARDIAL DEGENERATION	(?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad M. D.
Address 905 W. Baltimore Date signed 9/24/45

Continued for Additional Items

X

G32642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G32642 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Darford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Baby Boy) Carman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/45

8. AGE: Years	Months	Days	If less than one day
			16 hr. 30 min.

9. Birthplace Baltimore - Maryland
(Town, county, and state)

10. Usual Occupation Pvt.

11. Industry or business U.S. Army

FATHER
12. Name Mr. Andrew Frederick Carman
13. Birthplace Union city, New Jersey

MOTHER
14. Maiden Name Miss Burlington
15. Birthplace New York, New York

16 (a) Informant Pvt Andrew Frederick Carman
(b) Address Middle River Md

17 (a) Burial (b) Date thereof 9-25-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cactus Valley
Location Baltimore Md

18 (a) Funeral director Joyce A. Farley
(b) Address Fulton & Fayette

19 (a) SEP 25 1945
(Date rec'd by registrar)

Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1945, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1945 to 9/23 1945 and that I last saw him alive on 9/23 1945

Immediate cause of death Congenital Atelectasis — Duration 16 hr 30 min

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Stitely Jr. M. D.
Address Bon Secours Hosp. Date signed 9/23/45

G32643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32643 Registered No. 1315Q

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 351-S. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 351-S. Bentalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Smidt.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife John H. Smidt.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13-1875

8. AGE: Years 70 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business - At home.

FATHER
12. Name A. Stolzenbach.
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant John H. Smidt.
(b) Address 531-S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 45
(month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

SEP 25 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd. 1945 at 12.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Sept 22 1945. and that I last saw h-er alive on Sept 22 1945.

Immediate cause of death Hypertension Cardiovascular Sclerosis

Due to Arteriosclerosis

Due to Chronic Nephritis

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C Ricketts M. D.
Address 2351 Wellesley Date signed 9-24-45

G32644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32644 Registered No.

The information requested on this certificate is necessary for the legal registration of death and the certificate should be completed with the greatest care. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 545 W. Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore 25 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 W. Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wylie L. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-3278

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Rose Lee Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1914

8. AGE: Years	Months	Days	If less than one day
31	6	6	hr. min.

9. Birthplace Prospect Prince Edward Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Hotel Rubbers Co

FATHER
12. Name Edward Scott
13. Birthplace Prospect Prince Edward Va

MOTHER
14. Maiden Name Maggie Bryer
15. Birthplace Prospect Prince Edward Va

16 (a) Informant Edward Scott
(b) Address 545 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Lebanon
Location Baltimore County Md

18 (a) Funeral director Joseph A. Lively
(b) Address 401 N. Mount St. Baltimore 23 Md

19 SEP 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 1:45 PM

21. I certify that death occurred on the date above stated that I attended deceased from 8/29 1945 to 9/23 1945 and that I last saw him alive on 9/22/45

Immediate cause of death Chronic Pulmonary Tuberculosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 Carroll Ave Date signed 9/25/45

VS 2

G32645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

Registered No. G32645

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 E. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 E Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Kotschenreuther

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1885

8. AGE: Years	Months	Days	If less than one day
60	8	10	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Holster

11. Industry or business: Penna. R.R.

FATHER
12. Name: Andrew Kotschenreuther
13. Birthplace: Germnay

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Frances Kotschenreuther
(b) Address: 3712 Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Rd.

18 (a) Funeral director: Fuly & Zeile Inc.
(b) Address: 403 S. Wolfe Street

SEP 25 1945 (Date received by Registrar) (b) Huntington Millsboro, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1945, at 1.15 P M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/25/45

G32646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32646

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Lewis

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation BOILER MAKER

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant MRS. LILLIAN MILLS (FRIEND
(b) Address 1911 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 26/45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly & Zeilerinc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) SEP 25 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Ross T. Entzian M.D.
Medical Examiner.
Date signed Sept. 24 1945

G32647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 A

G32647

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 E. 39th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 E. 39th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. SIWINSKI

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) November 16, 1878

8. AGE: Years 66 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Sierpc, Poland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business General Practice

FATHER
12. Name Joseph Siwinski
13. Birthplace Poland

MOTHER
14. Maiden Name Aniela Kisielewska
15. Birthplace Poland

16 (a) Informant Dr. Arthur G. Siwinski
(b) Address 5000 Roble Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

SEP 25 1945 (Date rec'd by reg.) (b) Hastings-Fox-Williamson Mfg. Co.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1945, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941, to Sept 23 1945, and that I last saw him alive on Sept 15 1945.

Immediate cause of death	Duration
Carcinoma of esophagus	6 mos
Due to	
Due to	
Other Conditions Metastases to lungs, liver, cervical lymph nodes	

(Include pregnancy within 3 months)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Tillman, M. D.
Address 3035 St. Paul St Date signed 9/24/45

G32648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

Registered No. G32648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 316 Lyndhurst St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 316 Lyndhurst St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

Zone 29

3 (a) FULL NAME Annie M. Roper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lindon A. Roper

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.) May 23, 1887

8. AGE: Years 58 | Months 4 | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and State)

10. Usual Occupation House Wife

11. Industry or business

FATHER

12. Name Chas. R. Oettinger

13. Birthplace Germany

MOTHER

14. Maiden Name Mary E. Betz

15. Birthplace Germany

16 (a) Informant Lindon A. Roper

(b) Address 316 Lyndhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27. 1945 (month) (day) (year)

(c) Cemetery or crematory London Park

Location City

18 (a) Funeral director Mr. Mrs. John W. Tenfelder

(b) Address 801 W. Lafayette St.

19 (a) [illegible] Thurston Jon Williams M.D. (Registrant)

SEP 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945 at 10 30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Sept 24 1945 and that I last saw her alive on 9/23 1945.

	Duration
Immediate cause of death: General Carcinomatosis	2 Months
Due to: Carcinoma of Pancreas	1 Year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Elliot W. Johnson M. D.

Address 2432 Madison Date signed

MARY T.

G32649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G32649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 707 Mura St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days) 45 -

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 707 Mura St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary E. Fitzgerald

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John J. Fitzgerald

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) May 25, 1879

8. AGE: Years: 66 | Months: 3 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business:

FATHER 12. Name: Michael Newell

13. Birthplace: Ireland

MOTHER 14. Maiden Name: Anne A Burke

15. Birthplace: Ireland

16 (a) Informant: John J. Fitzgerald

(b) Address: 707 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27 (month) (day) (year)

(c) Cemetery or crematory: Dove Calvert Gardens

Location: 4300 Old Frederick Rd

18 (a) Funeral director: Edgar W. Coffin & Son

(b) Address: 224 E. Eager St.

SEP 25 1945 (Date rec'd by registrar)

(c) Huntington Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1945 at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-10 1945, to Sept 24-1945, and that I last saw her alive on Sept 23-1945.

Immediate cause of death	Duration
Edema of Lungs	3 days
Due to Cerebral Hemorrhage	10 days
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. North Av Date signed 9/24/45

VS 180

G32650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 M

Registered No. G32650

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Entry of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILMER Isabella Darrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Paul N. Darrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1897

8. AGE: Years	Months	Days	If less than one day
48	5	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Wilmer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Royal C. Thomsen
(b) Address Balto. Trust Bldg.

17 (a) Burial (b) Date thereof 9/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy.
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

SEP 25 1945
(Date rec'd by registrar)

(By) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1945, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to
Carbon Monoxide Poi.

Due to

Other Conditions Carcinoma of Breast
Cachexia - Dyspnea
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/23/45 at about 7:00 P.M.
(b) Where did injury occur? 3705 Maryland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? No
(d) Means of injury Automobile gas fumes

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 9/24/45

VS 151

G32651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G32651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6600 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. 35th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie F. Kirby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1873

8. AGE: Years	Months	Days	If less than one day
72	8	8	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joshua Shuler
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Lucinda Croll
15. Birthplace Carroll Co. Md.

16 (a) Informant Walter L. Kirby
(b) Address 3001 Batavia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) SEP 25 1945 Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945; at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Sept. 24 1945; and that I last saw her alive on Sept 20 1945

Immediate cause of death: Hypertensive Cardiovascular Renal Disease.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm D Talbert M.D.
Address 701 N. Fremont Ave. Date signed 9/26/45

X

G32652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46B

G32652 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR TYPEWRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607½ Warner
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607½ Warner
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Clark Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Richard Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1903

8. AGE: Years	Months	Days	If less than one day
41 42	9	16	hr. min.

9. Birthplace Scotland Neck, N.C
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jacob Clark
13. Birthplace N.C.

MOTHER
14. Maiden Name Nancy Wheel
15. Birthplace N.C

16 (a) Informant Rubena Dupree
(b) Address 607½ Warner St

17 (a) Removal (b) Date thereof 9-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Scotland Neck
Location N.C

18 (a) Funeral director Isaiah L. Brownson
(b) Address 101 N Montgomery St

19 (a) (Date received by registrar) SEP 25 1945 (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1945 to Sept 22 1945. and that I last saw h[illegible] alive on Sept 22 1945.

Immediate cause of death	Duration
Carcinoma of Stomach	6 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas H. Cabaniss M.D.

Address 517 Scott St Date signed 9/24/45

G32653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G32653

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME George Wieland Gorsuch

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-0894

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Dorothy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1906

8. AGE: Years	Months	Days	If less than one day
38	10	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Laundry Work
11. Industry or business

FATHER
12. Name Herbert Gorsuch
13. Birthplace md

MOTHER
14. Maiden Name Daisy Shipley
15. Birthplace md

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 9-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director C. H. Walz
(b) Address Winfield, Md

19 (a) SEP 25 1945 (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 1 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1945, to Sept 25 1945, and that I last saw h i alive on 19

Immediate cause of death	Duration
Pulm. Edema	
Sept. coma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Md. State Hosp. Date signed 9/25/45 M. D.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32654

480 843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G32654

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N. Y. (b) County

(c) City or town Binghampton (If outside city or town limits, write RURAL and give town)

(d) Street No. 56 Chestnut St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lawrence Kane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-87

8. AGE: Years	Months	Days	If less than one day
58	6	19	hr. min.

9. Birthplace N.Y. (Town, county, and state)

10. Usual Occupation Carpenter.

11. Industry or business

FATHER 12. Name John Kane

13. Birthplace Pa.

MOTHER 14. Maiden Name Mary Horgan

15. Birthplace Pa

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) [redacted] Burial (b) Date thereof 9/29/45 (month) (day) (year)

[redacted]rial, cremation, or removal)

Cemetery or crematory St. Patricks Cemetery

Location Binghampton, N.Y.

18 (a) Funeral director H. W. Mears & Son

(b) Address 845 N. Calvert St.

19 (a) (b)

SEP 25 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 25 1945, at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1945, to Sept. 25 1945, and that I last saw him alive on Sept. 25 1945.

Immediate cause of death Brain Tumor — post operative.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/24/45

Major findings of operation:

of autopsy: Brain Tumor - Fibrillo Astrocytoma

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. W. Chambers M.D.

Address Wm. Hopkins Hosp. Date signed 9/25/45

Balto. Md.

G32655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G32655 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 6 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Lena Elizabeth Heddrich

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry C. Heddrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18, 1877

8. AGE: Years 68 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Housework

FATHER
12. Name Frederick Hundertmark
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Henry C. Heddrich
(b) Address 502 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 210 Frederick Ave

SEP 25 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1945, at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Sept 23 1945, and that I last saw h[illegible] alive on Sept 23 1945.

	Duration
Immediate cause of death General carcinomatosis	6 months
Due to Gastric carcinoma	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 20 1945.
Major findings of operation: Carcinoma of stomach - metastatic carcinoma of liver & bowels.
Of autopsy: Of liver & bowels.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 23 1945

G32656

G32656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Weldon St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Weldon St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Johnston Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Norma Holton Thomas
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) March 10, 1885

8. AGE: Years	Months	Days	If less than one day
60	6	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Receiving Clerk
11. Industry or business Retired.

FATHER
12. Name Nelson A. Thomas
13. Birthplace Louisiana

MOTHER
14. Maiden Name Carolina Stipp
15. Birthplace Maryland

16 (a) Informant Norma H. Thomas
(b) Address 1114 Weldon Ave Zone 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 1945 (month) (day) (year)
(c) Cemetery or crematory Asbury M.E.
Location Pikesville, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

SEP 25 1945 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1945 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 23 1945. that I last saw him alive on Sept 22 1945.

Immediate cause of death	Duration
Congestive Heart failure	
Due to Arteriosclerotic C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H. Glassman M.D.
Address 4037 Falls Rd. Date signed 9/25/45

G32657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 108

G32657 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cella Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

X

3 (a) **FULL NAME** Charles H. Bockmiller

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Jennie Bogmed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-22-1861

8. AGE: Years	Months	Days	If less than one day
84	1	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Bockmiller
13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Emily Bunting
15. Birthplace Unknown

16 (a) Informant Mrs. Evelyn Harris
(b) Address 918 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address 408 Reed St. Cor. Lee Eastons Md

19 (a) (Date rec'd by registrar) (b) Registered

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1945, at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1945, to 9/24 1945, and that I last saw him alive on 9/24 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	9/24/45
Due to Arteriosclerotic Vascular Disease Cerebral Thrombosis with	
Due to complicating Lobar pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Bailey M. D.
Address Mercy Date signed 9/24/45

VS 150

X

G32658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G32658

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Prince George

(c) City or town Hyattsville

(If outside city or town limits, write RURAL and give town)

(d) Street No. 5307 Crittenden St.

(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Emanuel Stanton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Stanton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
57				

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER

12. Name Grant Stanton

13. Birthplace Maryland

MOTHER

14. Maiden Name Nellie Smith

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address Redwood & Greene Sts

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-25-45 (month) (day) (year)

(c) Cemetery or crematory Hyattsville

Location Hyattsville Md.

18 (a) Funeral director Francis Fraser Sons

(b) Address Hyattsville, Md.

19 (a) Huntington Williams, M.D.

(Date received by registrar) SEP 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945, at 8:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1945 to 9/29 1945, and that I last saw him alive on 9/26 1945.

Immediate cause of death Respiratory Failure

Due to Metastatic Carcinomatosis (Diffusa)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John M. Dennis

Address University Hospital Date signed 9/25/45 D.

X

G32659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G32659 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5833 Park Heights Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-19
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5833 Park Heights Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Michael Gaffney,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife Louise G. Gaffney,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1855

8. AGE: Years	Months	Days	If less than one day
90	0	16	hr. — min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Fire Dept.

FATHER
12. Name Michael Gaffney,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Mary Hampton,
15. Birthplace Ireland,

16 (a) Informant Mrs. C.B. Harryman,
(b) Address 2901 Allendale Rd.

17 (a) Burial, (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto. Co. Md.

18 (a) Funeral director Herman Sommers
(b) Address 4611 Park Heights Ave.,

19 9/25/1945 (Filed by registrar) Thurlington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1945, at 12:05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1945, to Sept 24th 1945; and that I last saw him alive on Sept 24 1945.

Immediate cause of death	Duration
Cerebral embolism	2½ hrs.
Due to Myocarditis	4 yrs.
Due to	
Other Conditions Arteriosclerosis	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. de Barbin M. D.
Address 4723 Pk. Hgts. Ave. Date signed 9/25/45.

Myocarditis Albert Lee Gaston M.D.

G32660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G32660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Woodhome Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Woodhome Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Schalitzky

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-4597

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Catherine Schalitzky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Pipefitter
11. Industry or business

FATHER
12. Name Anton Schalitzky
13. Birthplace Maryland

MOTHER
14. Maiden Name Bertha Gimber
15. Birthplace Germany

16 (a) Informant Mrs. Anna Mc Killop
(b) Address 3118 Woodhome Avenue

17 (a) Burial (b) Date thereof 9/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

SEP 26 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 to Sept 24 1945.
and that I last saw h alive on Sept 23 1945

Immediate cause of death
Coronary Thrombosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 2687 Mayfield Ave Date signed Sept 25 45

6326 61

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 18 D

Registered No. 6326 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Woodland Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Woodland Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Maynard Tier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Douglas

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.) Sept 18 1867

8. AGE: Years 78 | Months | Days 16 | If less than one day hr. min.

9. Birthplace Easton Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John M. Satterfield
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Clark
15. Birthplace Easton Md

16 (a) Informant Mary Virginia Tier
(b) Address 401 Woodland Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson Bros Inc
(b) Address 2101 E Fort Ave

SEP 26 1945 (Date rec'd by registrar)

(a) Washington Williamson Mill

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1945 to Sept 24 1945 and that I last saw h[e] alive on Sept 24 1945

Immediate cause of death Acute Cardiac Dilatation — Duration 1 day

Due to

Due to — 1 day

Other Conditions Cerebral Hemorrhage — 6 years
Hypertension: Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Hannan M. D.
Address 11 E. Chase St Date signed 9/26/45

O'Connor

VS 150

G32662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G32662 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 Radnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Radnor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Schmidt

3 (b) If veteran, name war: 10
3 (c) Social Security Account No. 705-09-6570

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie E Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20 1869

8. AGE: Years 75 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Engineer Mfg Products
11. Industry or business Prod Co

FATHER
12. Name Leopold Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Kuhl
15. Birthplace Germany

16 (a) Informant Fannie E Schmidt
(b) Address 503 Radnor Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto Md

18 (a) Funeral director Wilhem Cake Inc
(b) Address 1219 E Cold Spring

19 SEP 26 1945 (Date rec'd by registrar) (Signature of Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Sept 24 1945 and that I last saw him alive on Sept 24 1945.

	Duration
Immediate cause of death: Lobar Pneumonia	6 days
Due to:	
Due to: Chr. Interstitial Nephritis	3 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl J. Benson, M.D.
M. D.
Address 5111 York Rd Date Sept 25, 1945

G32663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G32663

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Wilabay Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Evelyn Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband Raymond T. Griffin

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Feb. 24 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	7	10		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Walston
13. Birthplace Md

MOTHER
14. Maiden Name Mary Eliz. Gardner
15. Birthplace Md

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

SEP 26 1945 (b) Huntington, Md.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 24 1945 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 19, 1945 to SEPT. 24 1945 and that I last saw HER alive on SEPT. 24 1945

Immediate cause of death CORONARY THROMBOSIS — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Shirley M. D.
Address 1213 Light St. Date signed 9-24-45

VS 150

G32664 G32664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Brooklyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 254
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3718 Brooklyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma G Stout

3 (b) If veteran, name war None | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Garret A Stout

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name David Bailey
13. Birthplace England

MOTHER 14. Maiden Name Johnson
15. Birthplace

16 (a) Informant Garret A Stout
(b) Address 3718 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Haven Md

18 (a) Funeral director Wilhelm Eckhardt
(b) Address 1217 E Fayette St

SEP 26 1945 (Date rec'd by Registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1945 at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Sept 25 1945 and that I last saw her alive on 9/20 1945

Immediate cause of death — Duration

Cerebral edema

Due to

Due to Hypertension Cardiovascular

Other Conditions diseases Coronary Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rabin M. D.
Address 203 Calaper Ave Date signed

VS 150

G32665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 M

G32665 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Broadway
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mattie Longworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife. Perry
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 20, 89

8. AGE: Years	Months	Days	If less than one day
53	3	5	hr. min.

9. Birthplace Spotsylvania Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John F. Woodard
13. Birthplace Spotsylvania Va.

MOTHER
14. Maiden Name Emma Brown
15. Birthplace Spotsylvania Va.

16 (a) Informant Mr. Perry Longworth
(b) Address 1526 N. Broadway

17 (a) Burial (b) Date thereof Sept 27, 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley
Location Baltimore

18 (a) Funeral director Agnes Lutz
(b) Address 1203 N. Broadway

19 (Date received) SEP 26 1946 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1946, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1946 to 9/25 1946 and that I last saw her alive on 9/24 1946

Immediate cause of death	Duration
Cachexia	
Due to Generalized Carcinomatosis abdominal viscera	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations As above
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address 1101 Keyser Bldg. Date signed 9/25/46

G32666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602

G32666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address John Street & Lafayette Ave.

(c) Hospital or institution: Hospital for the Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. John Street & Lafayette Ave. (If rural give location)

(e) Citizen of foreign country? 1920 E. Lafayette Ave (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Dunstan

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	New born

6 (b) Name of husband or wife: New born

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation New born

11. Industry or business

FATHER

12. Name Frederick Minnick Dunstan

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name Violet Leona Dunstan

15. Birthplace Stevensville Md.

16 (a) Informant Mother

(b) Address 1920 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 45 (month) (day) (year)

(c) Cemetery or crematory Mountcastle

Location Harford Rd

18 (a) Funeral director L. HECHMANN & SON

(b) Address 32 S. Broadway

19 Sept 26 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25th 1945, at 5 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23rd 1945, to Sept 25 1945, and that I last saw h[illegible] alive on Sept. 25th 1945

Immediate cause of death: Respiratory failure — Duration: 2 days

Due to: Intra-Cranial Hemorrhage

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: None Autopsy

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M. D.

Address Women's Hospital Date signed 9/25/45

VS 150

G32667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G32667 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Fred Johnson Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife: Mable J. Johnson
Nee Tubb
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1883.

8. AGE: Years	Months	Days	If less than one day
62	1	13	hr. min.

9. Birthplace Wicomico Co. Md (Town, county, and state)
10. Usual Occupation President
11. Industry or business J.F. Johnson Lumber Co.

FATHER
12. Name Wilmer M. Johnson
13. Birthplace Wicomico Co. Md.

MOTHER
14. Maiden Name Cattie Hayman
15. Birthplace Wicomico Co. Md.

16 (a) Informant Mrs. Mable J. Johnson
(b) Address Glen Burnie, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md.

18 (a) Funeral director Thomas W. Pinglelon
(b) Address Glen Burnie, Md.

19 (a) (b)

SEP 26 1945 Huntington Williamsport Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945, at 2 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1945, to 9-24 1945, and that I last saw him alive on 9-24 1945

Immediate cause of death Coronary occlusion — Duration 43 days.
Due to Myocardial degeneration
Pulmonary infarct
Due to congestive failure

Due to Rheu. Heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard G. Hennig, M. D.
Address University Hosp. Date signed 9-24-45

G32668

J1 - 12612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 6 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Conway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1867

8. AGE: Years 78 ? | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House wrk

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 25 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 26 1945 (Date rec'd by registrar) Signature of Registrar

2977

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1925 to Sept. 19 1945 and that I last saw her alive on Sept. 19 1945.

Immediate cause of death	Duration
Bronchopneumonia	6 da.
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave. Date signed 9-21-45

VS 150

632669 W0307 1

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

632669 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 N. Durham
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N. Durham (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22. 45

8. AGE: Years | Months | Days | If less than one day 9 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Miles
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bessie Carroll
15. Birthplace Baltimore, Md.

16 (a) Informant Bessie Carroll
(b) Address 218 N. Durham

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location SEP 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 26 1945 (Date rec'd by registrar) (S) J. J. Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1945 at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1945 to Sept 22 1945 and that I last saw he alive on Sept. 22 1945.

Immediate cause of death Malnutrition
Due to Premature Birth
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A Roy Berry M. D.
Address 1420 E. Chase Date signed 9-23-45

VS 150

2978

632670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No. 632670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2438. Chapel st.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 243 S. Chapel
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Dewald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Singer

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 2

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER

12. Name Martin Dewald

13. Birthplace Balto Md.

MOTHER

14. Maiden Name Mary

15. Birthplace Balto Md

16 (a) Informant George Dewald.

(b) Address 1110 S. Linwood Ave

17 (a) Burial (b) Date thereof Sept 26 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Carmel Cem

Location Donnell st.

18 (a) Funeral director Stiffler Featherston Inc

(b) Address 1000 S. Kenwood Ave

SEP 26 1945

(Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1945 to Sept 23 1945, and that I last saw h[illegible] alive on Sept 23 1945.

Immediate cause of death Acute Cardiac dilatation — Duration 1 day.

Due to Tobar Pneumonia — Duration 10 days.

Due to

Other Conditions Chronic Myocarditis — Duration 6 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John V. Szczerbakin

Address 1802 Carter Ave Date signed 9-25-45

M. D.

Szczerbakin

G32671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G32671

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 h. Rutland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 h. Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred M Flayhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frances Flayhart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1873

8. AGE: Years 72 | Months 6 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Retired Plasterer

11. Industry or business

FATHER
12. Name Joshua Flayhart
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Martha Leighton
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Frances Flayhardt
(b) Address 1706 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cemetery
Location Baltimore Maryland

18 (a) Funeral director Albert L Holt Jr
(b) Address 1806 E Chester Street

19 (a) SEP 26 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 2:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1938, to Sept 25 1945, and that I last saw h[illegible] alive on Sept 25 1945.

	Duration
Immediate cause of death: Acute Cardiac failure	1 day
Due to: Arteriosclerosis	7 yrs +
Due to: Bronchial Asthma	5 yrs +
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel Schmucker M. D.
Address 110 N. Wilton Ave Date signed 9-26-45

VS 150

G32672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G32672

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2444 Annapolis ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2444 Annapolis ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Carroll

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Julia Carroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1880

8. AGE: Years	Months	Days	If less than one day
64 65	9	26	hr. min.

9. Birthplace Kent County Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Office Building

FATHER 12. Name William A. Carroll
13. Birthplace Kent Co Md

MOTHER 14. Maiden Name Annie Carroll
15. Birthplace Kent Co Md

16 (a) Informant Mrs Julia Carroll
(b) Address 2444 Annapolis Ave

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director J. Preston Lupkins
(b) Address 519 Mosher St

19 (a) 9-26-1945 (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Sept 24 1945, and that I last saw h alive on Sept 21 1945.

Immediate cause of death	Duration
Tuberculosis of Both Lungs	8 mo.
Due to Tuberculosis	8 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Williams M. D.
Address 3 Wheelers Henry Md Date signed 9/25/45

VS 2

G32673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

98D

G32673 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 Crofton Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1340 Crofton Rd
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Wright Kenney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Louis E. Kenney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4th 1871

8. AGE: Years	Months	Days	If less than one day
74	0	19	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county and state)
10. Usual Occupation Retired Conductor
11. Industry or business B & O R.R.

FATHER
12. Name David Kenney
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informant Mrs Palmer C. Williams
(b) Address 5623 Pilgrim Rd.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 19 SEP 26 1945 Huntington Woods

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23rd 1945, at 1130 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1945 to 9/23 1945
and that I last saw h~~im~~ alive on 9/23 1945.

Immediate cause of death	Duration
Coronary Thrombosis	24 hrs
Due to Arterio-Sclerosis Myocarditis	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W W Hardy M.D.
Address 1403 Parkwood Date signed 9/25/45

G32674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G32674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2217 Eutaw Place

(c) Hospital or institution

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2217 Eutaw Place (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie W Dellak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 79 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Julius Steinitz

13. Birthplace Hungary

MOTHER 14. Maiden Name Nanette

15. Birthplace Hungary

16 (a) Informant Margaret Wolfarth

(b) Address 2217 Eutaw Place

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)

(c) Cemetery or crematory Balt Hebrew

Location Belair Rd

18 (a) Funeral director Jack Levy Inc

(b) Address 1439 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 26 1945

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25- 1945, at 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1945, to Sept 25 1945, and that I last saw her alive on Sept 25 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to	
Due to Arteriosclerosis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Frederick Lentz M. D.

Address Temple Gardens Apts Date signed 9/26/45

X

G32675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945

G32675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2445 Wood-Brookline
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Woodbrook ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ada T Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Widow

6 (b) Name of husband or wife George Smith
6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace North Thumberland Co Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Stepteau
13. Birthplace North Thumberland Co Va

MOTHER
14. Maiden Name Lydia Stepteau
15. Birthplace North Thumberland Co Va

16 (a) Informant William Stepteau
(b) Address 2445 Woodbrook ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 1945 (month) (day) (year)
(c) Cemetery or crematory Potts Memorial
Location Frederick Rd.

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley ave

19 (a) [illegible] (b) [illegible] Registrar

SEP 26 1945

Thurlington Williams, M.D.

VS 150

9/22/45

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1945, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945 to Sept 22 1945, and that I last saw her alive on Sept 22 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. M. Patterson, M.D.
Address 2324 Reisterstown Rd Date signed 9/25/45

G32676

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

G32676 Registered No.

Please write plainly. Physicians: please write the causes of death clearly and legibly. Accuracy as to age is especially important. Physicians should be careful to see that all information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 W. Barre Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Henry Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Roxboro N. C. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Tom Rogers
13. Birthplace N. C.

MOTHER
14. Maiden Name Mattie Z
15. Birthplace N. C.

16 (a) Informant Thomas Rogers
(b) Address 602 W Barre St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Danville Va
Location

18 (a) Funeral director Daniel L Brown Sr
(b) Address 04 W Montgomery St

19 (a) (Date rec'd by registrar) SEP 26 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945, at 3 45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Real death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-23-45 at 11 30 P. M.
(b) Where did injury occur? 602 W. Barre Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Robert L. Faker M.D. Medical Examiner.
Date signed Sept. 24 1945

G32677
CWK-95408

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32677
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 1- 10
(e) Length of stay in Baltimore (yrs., mos., or days) 44- 10- 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Morgan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Georgia Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10-1900

8. AGE: Years	Months	Days	If less than one day
44	10	15	hr. min.

9. Birthplace Baltimore-Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Morgan (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida ? (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Sept 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs. Robert Ellwood
(b) Address 1129 N. Caroline St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.
SEP 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1945, to Sept. 25 1945, and that I last saw h in alive on Sept. 25 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert P. Copeland M.D.
Address Balto. City Hosp. Date signed 9/24/45
M. D.

G32678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32678 Registered No. 183

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Dry Dock Co
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Vernon

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1905

8. AGE: Years	Months	Days	If less than one day
40	7	11	hr. min.

9. Birthplace Greenville S. Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Maryland Dry Dock

FATHER
12. Name John Vernon
13. Birthplace S.C.

MOTHER
14. Maiden Name Anna Perkins
15. Birthplace S.C.

16 (a) Informant Pauline Vernon
(b) Address 1225 E. Madison St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 27/45 (month) (day) (year)
(c) Cemetery or crematory
Location Greenville S. Carolina

18 (a) Funeral director Mrs. Robert A. Elliott Dft
(b) Address 1129 N. Carolina St.

19 (a) (Signature or Registrar) (b) Hunting Williams Dft Registrar

SEP 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 2:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 25, 1945 at 2:05 P.M.
(b) Where did injury occur? Maryland Dry Dock
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell overboard

23. Signature Robert A. Elliott M.D.
Medical Examiner.
Date signed 9-25-45

G32679

A B-90796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 A

G32679 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia White (Bialowzynski) (Bialozynski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7- 1886

8. AGE: Years	Months	Days	If less than one day
59	3	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Zamenski
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Balster
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Rec
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. Md.

18 (a) Funeral director W. S. Fialkowski
(b) Address 2007 Eastern Ave

SEP 29 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-25- 1945, at 12.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22- 1945 to 9-25- 1945 and that I last saw h 6r alive on 9-25 1945

Immediate cause of death: Debilitation due to Carcinoma of cervix.

Duration: ?

Due to

Due to

Other Conditions Hypertensive Cardiovascular disease. Hemiplegia (Rt)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret A. Davis M. D.
Address 4940 Eastern Ave. Date signed 9-25-45

G32680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32680

EB 89355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1-15 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2117 Dennison St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME George Satterfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Katharine (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28-1882

8. AGE: Years 63 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Satterfield(d)

13. Birthplace Md.

MOTHER 14. Maiden Name Katherine White(d)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Edmondson Ave.

18 (a) Funeral director Deacon's Rock Inc

(b) Address 1217 St Paul Street

(c) SEP 26 1945 (Date rec'd by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10- 1945, to 9-25 1945, and that I last saw h. alive on 9-25- 1945

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to:

Due to:

Other Conditions Osteomalacia Ut. Disease, Parkinsonianism, (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Bronchopneumonia, Ca. ut., advanced.

of autopsy: tumor ut.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret M. Dorn M. D.

Address 4940 Eastern Ave. Date signed 9-26-45

VS 150

X

G32681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No. G32681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1474 Stevens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John A. Thomas. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-79

8. AGE: Years	Months	Days	If less than one day
65	11	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16. (a) Informant Marie A. Haube
(b) Address 1609 Bedford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 26-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A. Co.

18 (a) Funeral director Carl. Bell.
(b) Address 1501 E Fort one.

19 SEP 26 1945 (b) Huntington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1945 at 11:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1945 to Sept 23 1945 and that I last saw h[illegible] alive on Sept 23 1945

Immediate cause of death Ruptured Aortic aneurism into Esophagus — Duration

Due to Syphilis

Due to

Other Conditions Acute meningitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rupture of Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ehrlich M. D.
Address 1213 Light St. Date signed 9-27-45

VS 150

G32682
JL - 96201

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131B

G32682
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Weisman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Fabes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1900

8. AGE: Years	Months	Days	If less than one day
45 yrs ?	?	?	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Ryatt
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Perlook
15. Birthplace Russia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

SEP 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 6.10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1945, to Sept. 25 1945, and that I last saw h er alive on Sept. 25 1945.

Immediate cause of death	Duration
Uremia & Cardiac Failure	
Due to Chronic Nephritis	
Due to	
Other Conditions Definite Gangrene of both feet	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. R. Cutler M. D.
Address Bact. Atty Hosp Date signed 9-25-45

Dr. Needle
4814 W. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G32683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Clifton Avenue-16- (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Estella Geiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Edward A. Geiger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1868

8. AGE: Years	Months	Days	If less than one day
77	--	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick J. Greener
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Silljacks
15. Birthplace Maryland

16 (a) Informant Mr. Edward A. Geiger
(b) Address 2822 Clifton Avenue-16-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Puck
(b) Address 5305 Harford Road

SEP 26 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Sept. 24 1945, and that I last saw h[illegible] alive on Sept 22 1945.

Immediate cause of death	Duration
Carcinoma Breast	
Metastatic Carcinoma	Longer
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. E. Needle, M.D.
Address 314 - W North Ave Date signed 9/24/45

VS 150

N. E. Needle

C32684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 A

Registered No. C32684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: So. Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 617 E. 37th St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard Peterson

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-0834

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna W. Peterson

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 9-15-78

8. AGE: Years	Months	Days	If less than one day
67	2	10	____ hr. ____ min.

9. Birthplace Balto., Maryland (Town, county, and state)

10. Usual Occupation Engineer.

11. Industry or business Burley Brothers

FATHER 12. Name Edward Peterson

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Mary A. Taylor

MOTHER 15. Birthplace Virginia

16 (a) Informant Anna W. Peterson

(b) Address 617 E. 37th St.

17 (a) 9-28-45 (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory, Lawnview Park

Location Baltimore Md

18 (a) Funeral director J. J. Rush

(b) Address 1545 N. Monroe St.

SEP 26 1945

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1945, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23, 1945 to Sept. 25, 1945 and that I last saw him alive on Sept. 25, 1945.

Immediate cause of death	Duration
Cerebro-vascular Accident	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature S. Ehrlich M. D.

Address 1213 Light St. Date signed 9-27-45

VS 150

G32685

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 124

G32685 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore & Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7201 Dunwood Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Phelip M^c Ginnis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Evelyn M^cGinnis
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) Sept 9, 1903

8. AGE: Years	Months	Days	If less than one day
42	0	15 16	..... hr. ..... min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business

FATHER
12. Name Patrick M^cGinnis
13. Birthplace Ireland

MOTHER
14. Maiden Name Delia Daley
15. Birthplace Ireland

16 (a) Informant Evelyn Mc Ginnis
(b) Address 7201 DUNWOOD COURT DUNDALK MD

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof Sept. 27-45 (month) (day) (year)
(c) Cemetery or crematory CHICAGO ILL
Location "

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E West St

19 SEP 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1945 to Sept 25 1945, and that I last saw him alive on Sept 25 1945.

Immediate cause of death	Duration
Profound shock	1 day
Septicemia	
Due to Acute Hemorrhagic Pancreatitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Acute Hem. Pancreatitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Wheeler M.D.
Address South Balto Gen Hos Date signed 9/25/45

G32686

DIEKMANN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G32686

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto. (b) County —
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6226 Fairdel Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Judith Diekmann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1942

8. AGE: Years	Months	Days	If less than one day
3	8	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Thomas, Julian
13. Birthplace Va

MOTHER
14. Maiden Name Florenz Diekmann
15. Birthplace Md

16 (a) Informant records
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29/1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location —

18 (a) Funeral director Harry N. Comacook
(b) Address 4204 Ridgewood Ave

19 (a) Sep 26 1945 (b) Huntington Ave Balto Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1945, to 9/26 1945, and that I last saw her alive on 9/26 1945.

Immediate cause of death	Duration
Diffuse Peritonitis	
Due to Perforated Appendix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/25/45

Major findings of operation: Perforated Appendix Diffuse Peritonitis

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Alex O. Tilly Jr

Address Mercy Hosp Date signed 9/26 M. D.

632687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 161 C

632687

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore – Md. Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Rt. Wing Drive.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country

3 (a) FULL NAME James Allen Koons

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			1 hr. 25 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Newborn Infant.
11. Industry or business

FATHER
12. Name George Maynard Koons
13. Birthplace Waynesboro, Pa

MOTHER
14. Maiden Name Charlotte Royer Frantz
15. Birthplace Waynesboro, Pa.

16 (a) Informant Mrs. Charlotte Koons
(b) Address 8 Rt. Wing Drive, Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2[illegible] (month) (day) (year)
(c) Cemetery or crematory Green Hill Cemetery
Location Waynesboro, Pa.

18 (a) Funeral director Walter E. Shore
(b) Address 71 Church St Waynesboro, Pa

19 (a) SEP 26 1945 (b) Huntington Williams M.D.
(Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 10:[illegible] AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1945, to Sept 25 1945, and that I last saw her alive on Sept 25 1945.

Immediate cause of death	Duration
Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd Jr. M.D.
Address St. Joseph's Hospital Date signed 9/26/45

VS 180

G32688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32688 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 Webb Court
(c) Hospital or institution:

10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DAVID McALLISTER

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	214-01-1907	Male	White	Married

6 (b) Name of husband or wife Maggie May Moore
6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Paperhanger
11. Industry or business DeMuth Co. Net. 3 yrs.

FATHER
12. Name William McAllister
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Adelle Love
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Maggie M. McAllister
(b) Address 948 Webb Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address N. AVE. & BROADWAY

SEP 28 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH September 25 1945, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 25 1945 and that I last saw him alive on Sept 25 1945.

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic myocarditis	2 yrs.
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave. Date signed Sept 25-45

VS 150

632689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

632689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 W. Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No), If yes, name country

3 (a) FULL NAME Estella Young (Taft Gunthrop)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1914

8. AGE: Years 31 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Hill
13. Birthplace South Carolina

MOTHER
14. Maiden Name Rebecca Blackmore
15. Birthplace South Carolina

16 (a) Informant Fred Gunthrop
(b) Address 214 W. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by Registrar) SEP 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943 to Sept 20 1945 and that I last saw her alive on Sept 20 1945

Immediate cause of death: (a) Coronary heart — Duration: 2 years
Due to: (b) Disease
Due to: (c)
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. H. Watts M. D.
Address 5154 Eng[illegible] Date signed 9/26/45

G32690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓163H

Registered No. G32690

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 William St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Curry

3 (b) If veteran, name war: 229-09-4731
3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Bessie Mae Curry
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) [illegible] 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Bett. Forfeld

FATHER
12. Name Henry E. Curry
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie Campbell
15. Birthplace Va.

16 (a) Informant Mrs. H. Elmer Curry
(b) Address 1239 William St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Lavington. Va
Location
18 (a) Funeral director J. J. Foley Sons
(b) Address 318 Light St.
19 SEP 26 1945 (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 25 1945 A.M.
(b) Where did injury occur? 1239 William St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Illuminating gas

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Sept 25 1945

VS 151

G32691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32691
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hartford Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 Fairhaven Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME [redacted] Leonard J. (FRANCKOWIAK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1945

8. AGE: Years	Months	Days	If less than one day
0	2	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Leonard T. Franckowiak
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Antoinette Jazelski
15. Birthplace Baltimore, Md

16 (a) Informant father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 27 45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem.
Location Baltimore City

18 (a) Funeral director John J. Welsh
(b) Address 461 S. Chester Street

19 (a) SEP 26 1945 (Date received by registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 3 a.m. p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1945 to Sept. 25 1945, and that I last saw h. l. alive on Sept. 25 1945.

	Duration
Immediate cause of death Pneumonia	3 days.
Due to Pertussis	5 weeks.
Due to	
Other Conditions Atelectasis of upper lobe	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 9-25

X

(1) G32692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Patapsco Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Patapsco Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Wood

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	widower

6 (b) Name of husband or wife Fanny Wood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11. 28. 1866

8. AGE: Years	Months	Days	If less than one day
78	10	28	hr. min.

9. Birthplace Anne Arundel Co Md
(Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business —

FATHER
12. Name a.
13. Birthplace

MOTHER
14. Maiden Name a.
15. Birthplace

16 (a) Informant Franklin Wood
(b) Address same (son)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F. Kenny Inc & E. Hess
(b) Address 711 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsburg Md

SEP 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.26 1945 at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.15 1945 to 9.27 1945 and that I last saw h[illegible] alive on 9.27 1945

Immediate cause of death Coronary thrombosis

Due to arteriosclerotic heart disease.

Due to

Other Conditions senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1½ hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Summers M. D.
Address 104 E Patapsco Date signed 9.26.45

H. E. Summers

G32693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119A

G32693 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Mud. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 Bolton St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nancy Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of ~~husband or wife~~ Agnes Matha
6 (c) If alive, give age 1944 years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1944

8. AGE: Years	Months	Days	If less than one day
	11	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Elmer Smith
13. Birthplace W. Va.

MOTHER
14. Maiden Name Agnes Bozic
15. Birthplace W. Va.

16 (a) Informant Elmer Smith
(b) Address 1839 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/45 (month) (day) (year)
(c) Cemetery or crematory Jobe
Location Jobe, W. Va.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 795 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia, Mar 26 1945

SEP 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1945, to Sept 25 1945, and that I last saw h[illegible] alive on Sept 25 1945.

Immediate cause of death	Duration
Cardiac	
Due to dehydration	6 days
Due to Diarrhea & Vomiting	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dezelle Phillips M. D.
Address Md. Gen. Hosp. Date signed 9/25/45

G32694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

Registered No. G32694

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Unknown
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Found - Corner of Fayette St & (If rural give location) Fallsway
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 24 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 26 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1945, at 6 A.M. 20

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to Marked Coronary arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept. 8 1945

2981

G32695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G32695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Harpers Ave & Burkeland Sts

(c) Hospital or institution: West Balt Gen Hosp 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (21)
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2401 Smith Ave. (Dorchester Heights)
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lewis Kirschbaum

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-1331

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed or divorced.
Male	White	married

6 (b) Name of husband or wife (nee Ahrens) Louisa W. Kirschbaum

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 12, 1895

8. AGE: Years	Months	Days	If less than one day
50	3	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business City of Baltimore

FATHER

12. Name Frederick Kirschbaum

13. Birthplace Baltimore Md.

MOTHER

14. Maiden Name ~~Elizabeth Stanger~~ Louisa W. Kirschbaum

15. Birthplace ~~Germany~~

16 (a) Informant Mrs. Louisa W. Kirschbaum

(b) Address 2401 Smith Ave, Dorchester Heights, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto Md.

18 (a) Funeral director J. Raymond Grass

(b) Address 1402 Eutaw St. (30)

19 (a) (Attending Physician) (b)

SEP 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945, at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1945 to 9-25 1945 and that I last saw h.i.m alive on 9-25 1945

Immediate cause of death — CORONARY OCCLUSION — Duration

Due to (or)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury Auto C. Wooden

23. Signature

Address W.B.H. Date signed 9-26-45 M. D.

G32696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94A

G32696 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 315 N. Central Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)

(d) Street No. 315 N. Central Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1888

8. AGE: Years 56 Months 10 Days 13 If less than one day hr. min.

9. Birthplace Darlington, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethelehem Steel Co

FATHER 12. Name Jos. Douglas

13. Birthplace S.C.

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Mrs. Lillie Mason

(b) Address 1733 W. Leigh St. Richmond Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)

(c) Cemetery or crematory

Location Richmond Va

18 (a) Funeral director Elroy A. Wilson

(b) Address 1000 Pennsylvania Ave Washington, D.C.

19 (a) (b)

Name of Registrar Registrar

SEP 26 1945

VS 150

MEDICAL CERTIFICATION

9/24/45

20. DATE OF DEATH Sept 24th 1945 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 18 1945 and that I last saw him alive on Sept 18 1945.

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis

Due to

Other Conditions Pneumonia ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
one

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harris G. Imie M. D.

Address 118 Risquith St Date signed 9/26/45

G32697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

G32697

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Annie Jones
(b) Address 16 N. Dallas St

17 (a) Burial (b) Date thereof 9/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Elroy A Wilson
(b) Address 1000 Broadway ave

19 (a) 9-26-1945 (b) for Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-1945, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Chronic Poliomyelitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 9-23-45

VS 151

G32698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119 A

G32698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 809 Uhlette Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Hockenberry A. Barbara Jane Hockenberry.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		25 days.	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant Infant

11. Industry or business

FATHER

12. Name Jesse Delbert Hockenberry

13. Birthplace Rush Run Ohio.

MOTHER

14. Maiden Name Josephine Susan Letterock Letterock

15. Birthplace Rush Run Ohio

16 (a) Informant Father Jesse Delbert Hockenberry

(b) Address 809 Uhlette Ave Dalton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27-1945 (month) (day) (year)

(c) Cemetery or crematory Louden Park Cem.

Location Baltimore Md.

18 (a) Funeral director Francis Cook Sykes

(b) Address 1600 N. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1945; at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1945 to 9/24 1945, and that I last saw her alive on 9/24 1945.

Immediate cause of death Epidemic bleeding of newborn — Duration 16 days.

Due to

Due to

Other Conditions Prematurity — 25 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A Robert Marks M. D.

Address Univ. Hosp. Date signed 9/24/45

G32699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32699 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 N. Decker Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Decker Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louisa Anna Weiss

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-6612

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1913

8. AGE: Years	Months	Days	If less than one day
31	10	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name John A. Weiss
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Christina Stumpfner
15. Birthplace Baltimore, Maryland

16 (a) Informant Oscar Weiss
(b) Address 3032 Kenyon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Avenue

18 (a) Funeral director Frederick D. Mullen, Inc.
(b) Address 3019 E. Monument Street

9-27-1945 Date rec'd by (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1945, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1943, to 9-24 1945, and that I last saw h alive on 9-22 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 yrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Thoracoplasty 1 yr

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence N. Scott M. D.

Address 11 E. Chase St Date signed 9-26-45

G32700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

850 Registered No. G32700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Clinton St.
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 S. Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Mary Hedrick.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Robert K. Hedrick.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 13, 1859
8. AGE: Years 86 | Months 2 | Days 13. | If less than one day hr. min.
9. Birthplace Glen Rock, Pa. R.D. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home.

FATHER
12. Name Shaffer.
13. Birthplace Penna.

MOTHER
14. Maiden Name Eleanor Shaffer.
15. Birthplace Penna.

16 (a) Informant Mrs. William Young.
(b) Address 830 Clinton St, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof September 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Shrewsbury Lutheran
Location Shrewsbury, York Co, Pa.

18 (a) Funeral director Jacob Hartzler & Son
(b) Address Freedom, Pa.

SEP 27 1945

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1945; at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1945 to Sept 26 1945, and that I last saw h[illegible] alive on Sept 26 1945

Immediate cause of death: Hemorrhage into the Cerebrum — Duration: 5 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon
Address 129 S Bway Date signed 9/26/45.

VS 150

G32701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G32701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. Payson Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph George Hebrank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11th 1868

8. AGE: Years	Months	Days	If less than one day
77	0	15	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Painter

FATHER
12. Name John Hebrank
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Thalheimer
15. Birthplace Unknown

16 (a) Informant Marie A. Hebrank
(b) Address 4622 York Rd

17. Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Corkran
(b) Address 1219 E. Pratt St

19 SEP 27 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-1945, at 5:50 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fracture + dislocation of 2nd cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16-4

(a) Date of injury 9-26- at 4:30 P.M.
(b) Where did injury occur? 1100 block Payson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by R. R. Train

23. Signature Howard J. Mussen M.D.
Medical Examiner.

Date signed 9-26-45

VS 151

G32702

AB-94518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32702

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 8days

(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 800 N. Chester St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis LeHardy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Edna (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1885

8. AGE: Years	Months	Days	If less than one day
59	9	15	hr. min.

9. Birthplace France (Town, county and state)

10. Usual Occupation Cable Splicer

11. Industry or business Gas. Electric Co

FATHER — 12. Name Andrew LeHardy

13. Birthplace France

MOTHER — 14. Maiden Name Louise Guilloux

15. Birthplace France

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)

(c) Cemetery Balto. Md.

Location

18 (a) Funeral director William Cook Inc.

(b) Address 217 E. Paul St.

SEP 27 1945 (Date received by local registrar) Carrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 26 1945, at 3.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18- 1945, to 9-26 1945, and that I last saw h 1m alive on 9-26- 1945

Immediate cause of death	Duration
Tuberculosis of the Lungs	2
Tuberculosis Enteritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Same

of autopsy: Same

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert L. Garland Jr. M.D.

Address Balto. City Hosp. Date signed 9/26/45

VS 150

G32703 DeVINE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C Registered No. G32703

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 E. North Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Devine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 4th 1927

8. AGE: Years	Months	Days	If less than one day
18	3	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Devine
13. Birthplace Pa.

MOTHER 14. Maiden Name Madalene Trenner
15. Birthplace Md.

16 (a) Informant Records
(b) Address St Agnes Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 19 45 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945 to 9/25 1945
and that I last saw him alive on 9/25 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic Cardiac	
Due to Vasc Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

29. Signature Edith Lauff, J.
Address St. Agnes Hosp. Date signed 9/25/45 M. D.

VS 180

G32704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6-58

G32704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Berry St
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Berry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V. Shaffer

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Harold Shaffer
6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Sept 25, 1879

8. AGE: Years: 66 | Months: - | Days: 1 | If less than one day: hr. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Warner
13. Birthplace: Md.

MOTHER
14. Maiden Name: —
15. Birthplace: —

16 (a) Informant: Maurice Shaffer
(b) Address: 711 Berry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/28/45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Frederick Road.

18 (a) Funeral director: Howard N. Bligh Jr
(b) Address: 4914 Belair Road.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 27 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 1945, at 5.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945, to Sept 25 1945, and that I last saw her alive on Sept 25 1945.

Immediate cause of death	Duration
Due to: Metastatic Supersymptoms of Pelvis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: D. V. Thomas, M.D.
Address: 1235 Paca St Date signed: 9/24/45

Huntington Hillcrest, Md

G32705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

Registered No. G32705

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIV. HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. #1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 CAMDEN (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL DUVALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	NEWBORN

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-45

8. AGE: Years	Months	Days	If less than one day
			15 hr. 30 min.

9. Birthplace UNIV. HOSP. BALTO., MD. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name HARRY DUVALL
13. Birthplace

MOTHER
14. Maiden Name VIVIAN ELLARD
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 26 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

19 SEP 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 22 1945 at 7 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 22 1945 to SEPT 22 1945, and that I last saw he alive on SEPT 22 1945.

Immediate cause of death RESPIRATORY FAILURE — Duration

Due to FOETAL ATELECTASIS, BILATERAL HYDROTHORAX, BILATERAL SUBARACHNOID HEMORRHAGE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: SEE ABOVE

of autopsy: SEE ABOVE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Harwood M. D.
Address Univ. Hosp. Date signed 9-25-45

VS 150

12982

G32706

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131B

Registered No. G32706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Arunah Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLOTTE A. ARNREICH

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ferdinand Arnreich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1863

8. AGE: Years	Months	Days	If less than one day
82	7	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Moses Johnston
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Logan
15. Birthplace Ireland

16 (a) Informant Mrs. Louisa D. Wells
(b) Address 2309 Arunah Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 27 1945 (b) Entered by Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1945 at 1:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 24 1945
and that I last saw her alive on Jan 24 1945.

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis.
Due to
Other Conditions Nephritis & Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard S. Francke M.D.
Address 2379 Arunah Ave Date signed 9/27/45

VS 150

G32707

G32707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 600 S. Chapel Gate Lane

(c) Hospital or institution: Pinecrest Sanitorium

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 ?

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2615 Edmondson Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY Mac MILLAN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
None	None	Female	White	Widow

6 (b) Name of husband or wife William B. MacMillan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1863

8. AGE: Years	Months	Days	If less than one day
82	7	22	hr. min.

9. Birthplace Australia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Price

13. Birthplace Australia

MOTHER 14. Maiden Name

15. Birthplace Unknown

16 (a) Informant Mrs. Jessie Beveridge

(b) Address 2615 Edmondson Ave. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)

(c) Cemetery or crematory

Location Oak Hill, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) Received (b) Huntington Williams, Registrar, M.D.
SEP 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1945, at 8:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1945 to Sept 26 1945 and that I last saw her alive on 9/26 1945.

Immediate cause of death: Repeated Myocardial Infarct — Duration: 4 days

Due to

Due to

Other Conditions: General arteriosclerosis with Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. T. Alagy M. D.

Address 33 E. Madison St. Date signed 9/26/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G32708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1945 G205408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Dorchester Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Dorchester Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY WILD

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-01-6791

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Pfaff Wild
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4, 1877

8. AGE: Years 68 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Retired Mechanical Engineer

11. Industry or business

FATHER
12. Name: Frederick William Wild
13. Birthplace: Phila Pa.

MOTHER
14. Maiden Name: Bertha Von Fehleesen
15. Birthplace: Malden, N. Y.

16 (a) Informant: Mrs. Lenore Benson
(b) Address: 4603 Maine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Loudon Park Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: WM. J. TICKNER & SONS, INC.
(b) Address: Baltimore, Maryland

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1945, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Aug~~ 1943, to Sept 24 1945, and that I last saw h~~e~~ alive on ~~Aug~~ 24 1945.

Immediate cause of death: Coronary thrombosis — Duration
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Dr Wetherbee Fort
Address: 20 E. Preston St Date signed 9/26/45 M. D.

Huntington Williams, M.D. Wetherbee Fort

G32709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G32709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) 7 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Madison Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BRENDA ELLIOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-45

8. AGE: Years | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Brevel Elliott
13. Birthplace N. C.

MOTHER
14. Maiden Name Florence Bunn
15. Birthplace Phila Pa.

16 (a) Informant Florence Elliott
(b) Address 1218 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs Frances A Hemsley
(b) Address 578 W Biddle St

19 (a) (b) Huntington Avenue, Md

SEP 27 1945

VS T51

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/45 19..., at 7:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ward M.D.
Medical Examiner.
Date signed 9/26/45

G32710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G32710 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 Wash Blvd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Wash Blvd (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Catherine E. Trimper

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
female	white	married

6 (b) Name of husband ~~or wife~~ Mark J. Trimper
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 4/6/1874

8. AGE: Years	Months	Days	If less than one day
71	5	19	— hr. — min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Wineman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown.
15. Birthplace —

16 (a) Informant Mark J. Trimper
(b) Address 830 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western.
Location Edmondson. Ave.

18 (a) Funeral director Ambrose Doe
(b) Address 414 N. Franklintown Rd

19 (a) — (Date rec'd by registrar) (b) — Registrar

vs 188 SEP 27 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1945, at 6 ~~P.~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 9/25 1945 and that I last saw h~~e~~r alive on 9/24 1945

Immediate cause of death Hypertensive Cardia Vascular Disease — Duration 2

Due to — —

Due to — —

Other Conditions None —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Mary Learee
Address 226 Hunter St Date signed 9/25/45 M. D.

X

G32711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G32711 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring + Belvedere Aves.
(c) Hospital or institution: Levindale, Hebrew Home + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 W. Garrison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Leach

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Sam Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David —
13. Birthplace Russia

MOTHER
14. Maiden Name Mirra —
15. Birthplace Russia

16 (a) Informant Sophie Claire
(b) Address 3902 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Nat Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 27 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1945, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945, to 9-27 1945, and that I last saw h-- alive on 9-27 1945.

Immediate cause of death Chr. card. valvular disease — Duration
Diabetes Mellitus
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin M. D.
Address Levindale Date signed 9/27/45

G32712

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13D

G32712
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 Fairview
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Benjamin Friedman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 62

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Friedman
13. Birthplace Poland

MOTHER
14. Maiden Name ? ?
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Road
Location.....

18 (a) Funeral director Jack Lewis Inc
(b) Address 1739 E. Balto. St

19 (a) Date received by registrar SEP 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1945, at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1945 to Sept 26 1945 and that I last saw him alive on Sept 26 1945.

Immediate cause of death Cardiac Failure — Duration 7 days

Due to Arteriosclerotic heart disease — Duration 20 yrs

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature H.S. Dorsheimer M. D.
Address Johns Hopkins Hosp. Date signed 9-26-45

Huntington Ave Hospital

G32713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

G32713 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles Apartments
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2.5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles Apartments
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William McLean Yost

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Louise Austin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1870

8. AGE: Years	Months	Days	If less than one day
76	5	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Physician
11. Industry or business

FATHER
12. Name Richard D. Yost
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Eugenia McLean
15. Birthplace ?

16 (a) Informant Mr. S. Howard Smith
(b) Address 15 E. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (b)
(Signature and title) Registrar
SEP 27 1945
VS 151 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25- 1945, at 8:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-25-45 at 12/2 A. M.
(b) Where did injury occur? Charles Apartments
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury, Jumping in front of moving car - struck with head

23. Signature S. Howard Smith M.D.
Medical Examiner.
Date signed September 25, 1945

G32714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32714 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Scott St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vanna Greenfield

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace St Mary County (Town, county, and state)
10. Usual Occupation House work.
11. Industry or business

FATHER
12. Name Thomas Curry
13. Birthplace St Mary County

MOTHER
14. Maiden Name Alice Gray
15. Birthplace St Mary County

16 (a) Informant William Greenfield
(b) Address 305 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-45 (month) (day) (year)
(c) Cemetery or crematory near Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Kassnakos
(b) Address 60 W Washington St

19 (a) SEP 27 1945 (b) Huntington Williamsport, Md
(Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1945, at 8:30 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1945 to 9/26 1945, and that I last saw h alive on 9/26 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 1 da

Due to Hypertensive Cardio Vascular disease ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury None

Signature Joseph N Lanakas M. D.
Address 67 Washington St Date signed 9/26/45

G32715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32715 / 131 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 E. Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ned Settles

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
-	213-07-4155	Male	Negro	Married

6 (b) Name of husband or wife July 15, 1885
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
60	7	10		

9. Birthplace S. Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Millie Settles
(b) Address 1824 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellis
(b) Address 1129 N. Caroline St.

19 SEP 27 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25- 1945 at 6 P.M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 9-26-45

VS 151

G32716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45A

G32716 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 S. GLOVER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 S. GLOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MELVINA SCHROEDER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced.: WIDOW

6 (b) Name of husband or wife: GEORGE SCHROEDER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 12 1861

8. AGE: Years 84 | Months 11 | Days 14 | If less than one day hr. min. 13

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace BALTO.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO.

16 (a) Informant MARGARET REINSCH (DAUGHTER)
(b) Address 700 S. GLOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 28/45 (month) (day) (year)

(c) Cemetery or crematory MT. CARMEL
Location ODONNELL ST.

18 (a) Funeral director Tilly and Zeiler Bros.
(b) Address 403 S. WOLFE ST.

19 (a) SEP 27 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 26 1945 at 3 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Sept 26 1945 and that I last saw her alive on Sept 25 1945

Immediate cause of death: Cerebro-Cardio-Respiratory arrest. — Duration: one hr

Due to: Carcinoma of Liver & face — Duration: 3 yrs

Due to: — Duration:

Other Conditions: — Duration:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. J. Douglas M. D.
Address 900 E. Fayette Date signed 9/27/45

VS 150

AB-94920 G32717 BALTIMORE CITY HEALTH DEPARTMENT G32717
CERTIFICATE OF DEATH 13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos- 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Keene

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Vera
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 21-1898
8. AGE: Years 46 | Months 10 | Days 4 | If less than one day hr. min.
9. Birthplace Conn.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name Andrew Keene (D)
13. Birthplace Conn.

MOTHER
14. Maiden Name Mary Morrissey (D)
15. Birthplace Conn.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 28/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 S. WOLFE ST.
19 (a) SEP 27 1945 (Date rec'd by registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-25- 1945 at 2.40PM
21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1945 to 9-25- 1945 and that I last saw h 1m alive on 9-25- 1945

Immediate cause of death: Tuberculous Meningitis — Duration: 2.
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions: Empyema - Bronchio-Pleural Fistula
(Include pregnancy within 3 months of death)
Date of operation 7-29-45
Major findings of operation: Sama
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Herbert B. Blakeslee Jr. M.D.
Address Balto. City Hosp. Date signed 9-26-45

VS 150

G32718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. G32718

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 W 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 W 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca S. Broyles.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Peter W. Broyles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13, 1865

8. AGE: Years: 80 | Months: 7 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Newton Taylor.
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Otis R. Broyles
(b) Address: 801 W 38th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 28/45 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Hampden

18 (a) Funeral director: Schendorf & Sonneborn
(b) Address: 3615-17 Eastern Ave

19 SEP 27 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 24 1945 to Sept 25 1945, and that I last saw her alive on Sept 25 1945.

Immediate cause of death	Duration
Congestive Heart Failure	?
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Bronchopneumonia	2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Leonard Wallent M.D.
Address 801 W 36 Date signed Sept 27/45

VS 150

G32719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G32719

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Josephs Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 4814 Pimlico Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Esther Powell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Isaac J. Powell

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Aug 16 1920

8. AGE: Years	Months	Days	If less than one day
25	1	9	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George W. McFadden

13. Birthplace Maryland

MOTHER

14. Maiden Name Dola L. Hood

15. Birthplace Maryland

16 (a) Informant Isaac J. Powell

(b) Address 4814 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29/45 (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden

18 (a) Funeral director Chenowith & Bowman

(b) Address 1715-17 Chestnut Ave

SEP 27 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1945, at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1945 to 9-25 1945, and that I last saw her alive on 8-25 1945.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Rt. Ventricular Failure	Ventricular
Due to Pneumonic Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: T.B. of lungs at autopsy.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. E. Everett M. D.

Address 21 Gaylis Date signed 9/25/45

VS 150

G32720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lauden Ave + Madison St.
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 3328 Spaulding Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs. Lottie Tracey
(b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
(b) Name of husband or wife Joseph F. Tracey
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) Oct 24, 1883
8. AGE: Years 61 | Months 11 | Days 0 | If less than one day ... hr. ... min.
9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Noah Bosley
13. Birthplace Maryland.

MOTHER
14. Maiden Name Violet Harris
15. Birthplace Maryland.

16 (a) Informant Joseph F. Tracey.
(b) Address 3328 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29/45 (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Balto Co.

18 (a) Funeral director Chamberlain & Donovan
(b) Address 346 W Chestnut Ave.

19 (a) SEP 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1945 at 4:08 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1945 to Sept 26 1945, and that I last saw h.C. alive on Sept 26 1945.

Immediate cause of death Diabetes Mellitus

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Shellman
Address Md. General Hosp. Date signed 9/26/45

VS 3

G32721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32721 Registered No.

83P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AREAS RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1631 S Charles St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1631 S Charles St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna E Kley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1872

8. AGE: Years 73 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nelson Diver

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Johnson

15. Birthplace Md

16 (a) Informant Minnie F Hamill

(b) Address 1631 S Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Nelson & Hoge

(b) 1218 Lafayette Blvd

19 (a) SEP 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1945, at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 19 , to Sept 26 19 45 and that I last saw her alive on Sept 26 19 45

Immediate cause of death Edema of Lungs — Duration 48 hrs

Due to

Due to Cerebral Hemmorhage - 5 days.
Rt Hemiplegia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. L. Leibtreuberg M.D.

Address 708 E North Ave Date signed 9/27/45

VS 180

G327722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119 A

Registered No. G327722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fallsway & Eaton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Orville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacqueline Kaye Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1945

8. AGE: Years	Months	Days	If less than one day
1		22 23	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Kathleen Fisher
15. Birthplace Pennsylvania

16 (a) Informant Father
(b) Address 1445 Orville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery or crematory West Side
Location Sunbury Pa

18 (a) Funeral director Milton Cook Inc
(b) Address 1217 E Court St

19 (a) Sep 27 1945 (Date filed) (b) Huntington Willis (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1945 at 6:53 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1945 to 9-27 1945, and that I last saw her alive on 9-27 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Severe Dehydration	
Due to Infectious diarrhea of newborn.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Cook Jr. M. D.
Address 1 Physicians Park Date signed 9/27/45

G32723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32723 X 131A

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 W. St N. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vincent Greenfield.

3 (b) If veteran, name war | **3 (c) Social Security Account No.**

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	married

6 (b) Name of husband or wife Thelma.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-97

8. AGE: Years	Months	Days	If less than one day
48.	3	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Greenfield
13. Birthplace Md.

MOTHER 14. Maiden Name Christina Marshall
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Oct. 1, 1945 (b) Date thereof (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Washington D.C.
Location
18 (a) Funeral director E. B. McGuire
(b) Address 1820 9th St N.W.
19 (a) Oct 1 1945 (b) Registrar
SEP 27 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 2.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945, to Sept. 27 1945, and that I last saw him alive on Sept. 27 1945.

Immediate cause of death	Duration
Ventricular standstill	
Due to Ventricular tachycardia	
Due to Paroxysmal auricular tachycardia	
Other conditions Hypertensive cardiovascular disease - nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Nathan J. Dixon
Address Johns Hopkins Hospital Signed 9/27/45

G32724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G32724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 S Bimey st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 S. Bimey st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances M. Dembowczyk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3" 1945

8. AGE: Years | Months: 2 | Days: 24 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business

FATHER
12. Name Edward Dembowczyk
13. Birthplace Poland.

MOTHER
14. Maiden Name Lorretta Krainer
15. Birthplace Balto Md.

16 (a) Informant Mrs. Lorretta Debowczyk
(b) Address 1123 S. Bimey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Hoffburg Ave

18 (a) Funeral director Hopkins & Feathowstone Inc
(b) Address 1000 S. Elmwood Ave

19 (a) Registrar Huntington Williams M.D.
(b) Date received SEP 28 1945

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Sept 27 1945 and that I last saw h alive on Sept 27 1945

Immediate cause of death: Terminal Broncho Pneumonia — Duration 9/25/45

Due to Marasmus — 9/17/45

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Roane R
Address 801 - N Caroline St Date signed 9/28/45 M. D.

G32725 — 2-32116 — G32725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1194

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Howard
(c) Hospital or institution: University Hospital 25-2
(d) Length of stay in hospital or inst. (yrs., mos., or days): 18d.
(e) Length of stay in Baltimore (yrs., mos., or days): 18d.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3038 Seamore Ave - Cherry Hill (Or other description sufficient to locate)
(e) Citizen of foreign country? SERMON NE (Yes or No) If yes, name country:

3 (a) FULL NAME: Baby Girl Johnson

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Child

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-31-45

8. AGE: Years	Months	Days	If less than one day
18d.		18d.	hr. 16 min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Child

11. Industry or business:

FATHER
12. Name: ENOS JOHNSON
13. Birthplace: BALTIMORE Md

MOTHER
14. Maiden Name: VIOLETTA DORSEY
15. Birthplace: BALTIMORE MD

16 (a) Informant: Birth Certificate
(b) Address: G 32116

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: University Medical School SEP 20 1945

18 (a) Funeral director: Commissioner of Health
(b) Address:

19 SEP 28 1945 (Date rec'd by registrar) (Signature) Hunter Van Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16. 1945. at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1945. to 9-16 1945. and that I last saw h er alive on 9-16 1945.

Immediate cause of death: Prematurity — Duration:

Due to: Infections, Diarrhoa.
a. Pneumonia
b. Dehydration
c. Eclampsia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. Hunter Wade M. D.
Address: Univ Hosp. Date signed 9-17-45

2989

G32726 S-32100 G32726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Edward & Green
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne's
(c) City or town Queenstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy (Boulden) BOULDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1945

8. AGE: Years	Months	Days	If less than one day
		23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation CHILD

11. Industry or business —

FATHER
12. Name HAROLD LEE BOULDEN
13. Birthplace GRASONVILLE MD.

MOTHER
14. Maiden Name MARY ADELAIDE BAKER
15. Birthplace GRASONVILLE, MD.

16 (a) Informant BIRTH CERTIFICATE
(b) Address G 32100

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 28 1945 (Date rec'd by registrar) (Signature of) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1945 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1945 to 9-19 1945 and that I last saw him alive on 9-19 1945

Immediate cause of death Prematurity

Due to Infectious Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Esther E. Drake M. D.
Address Univ. Hosp. Date signed 9-19-45

VS 150

2988

G327727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83 A

G327727
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Pk. Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Brookfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yetta Leventhal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore & Gorsuch Sts

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

SEP 28 1945 (Date rec'd by Registrar) (b) Huntington Millwood, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1945 to 9/27 1945, and that I last saw h[illegible] alive on 9/27 1945.

Immediate cause of death	Duration
Acute cerebral Hemorrhage	
Due to Ch Arterio Sclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Hornstein
Address 733 Augusta St Date signed 9/27/45

VS 180

G32728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G32728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4139 Forest Pk. Ave
(c) Hospital or institution:

28 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4139 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Brownstein

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Volunteering Bus.
11. Industry or business

FATHER
12. Name Marx
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belgian Rd

18 (a) Funeral director Jack Levin Co
(b) Address 1439 E. Balto St.

19 (a) SEP 28 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-45 1945, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1942 to Sept 27 1945, and that I last saw him alive on Sept 27 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	12 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. W. Jacobson M. D.
Address 2310 Eutaw Place Date signed 9-27-45

VS 150

G32729
479572

LIPMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V91A

Registered No. G32729

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Norfolk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sondra Lipman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-34

8. AGE: Years	Months	Days	If less than one day
11	0	7	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Michael Lipman
13. Birthplace Penn.

MOTHER
14. Maiden Name Rena Kimmel
15. Birthplace Pa

16 (a) Informant Rennds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Southern Ave

18 (a) Funeral director Park Lawn
(b) Address 1439 E. Baltimore St

SEP 28 1945

(Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945 at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1945 to Sept. 27 1945 and that I last saw h[illegible] alive on Sept. 27 1945.

Immediate cause of death	Duration
Subacute Bacterial Endocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Howes, M.D.
Address Johns Hopkins Hosp. Date signed 9/29/45

VS 150

G32730 Nitsch

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G32730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkins & Caton Aves

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. North Rolling Rd (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Nitsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1945

8. AGE: Years	Months	Days	If less than one day
			24 hr. and 15 min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER

12. Name John J. Nitsch

13. Birthplace Baltimore Maryland

MOTHER

14. Maiden Name Catherine

15. Birthplace Baltimore, Maryland

16 (a) Informant Father

(b) Address North Rolling Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. Md.

18 (a) Funeral director George A. Fawley

(b) Address Fayette & Fulton Sts

19 (a) SEP 28 1945 (b) Huntington-Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1945 to 9/27 1945, and that I last saw h/m alive on 9-27 19 45.

Immediate cause of death	Interval between onset and death	Duration
(a) Prematurity		
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 9/29/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M. D.

Address St Agnes Hosp Date signed 9/28/45

X

G32733 3 5 7 D

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

G32731 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. Co.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 St. Helena Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patsy McMahon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-12-34

8. AGE: Years 11 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Frank McMahon
13. Birthplace Va.

MOTHER 14. Maiden Name Mildred Mason
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept. 28/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Eastern Ave.

18 (a) Funeral director John R. Miller
(b) Address 2334 Jefferson St. Carlington Williams, Md.

19 (a) SEP 28 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1945, at 9:07 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1945 to Sept 25 1945, and that I last saw her alive on Sept 25 1945.

Immediate cause of death: Pulmonary Hemorrhage
Due to: Tetralogy of Fallot
Due to:
Other Conditions: Congenital heart disease
(Include pregnancy within 3 months of death)

Duration

Date of operation Sept 1945
Major findings of operation: Tetralogy of Fallot
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Williams Hillman
Address Johns Hopkins Hospital Date signed 25 Sept 1945

114E

G32732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G32732 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkeland - Eagnor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Gaetze

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 216-20-3768

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie Goetze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13/1888

8. AGE: Years	Months	Days	If less than one day
57	8	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Henry Goetze
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katie Bonhart
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Katie Goetze
(b) Address 1633 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St.

19 Filed SEP 28 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1945, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1945 to 9/26 1945, and that I last saw him alive on 9/26 1945

Immediate cause of death Cardiac failure

Due to Arteriosclerotic Cardiac vascular disease

Due to Cerebral Hemorrhage

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
prob

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elder Baldwin
Address West Baltimore General Hospital Date signed 9/26/45

G32733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83D

G32733 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2818 Alvarado Square
(c) Hospital or institution:

27-T

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Alvarado Square (Alvarado) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma L. STURGIS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thaddeus C. Sturgis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 4, 1872

8. AGE: Years 73 | Months 5 | Days 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: George Barrett
13. Birthplace: Va.

MOTHER
14. Maiden Name: Mary E. Hoffman
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Ella Martin
(b) Address: 2818 Alvarado Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory: Rock Creek Cem.
Location: Washington, D. C.

18 (a) Funeral director: C. Howard Tickner
(b) Address: North & Penna. Ave., Balto., Md.

19 (Date received by registrar) SEP 28 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 2 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to 27 Sept 1945; and that I last saw her alive on 26 Sept 1945.

Immediate cause of death Uremia, Acute — Duration

Due to Paralysis, (Left Hemiplegia & involvement of pharynx)

Due to Arteriosclerosis, generalized

Other Conditions Hypertension, mild-

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Edward L. J. Mohr M. D.
Address 7329 Harford Rd. Date signed 27 Sept 45

VS 150

G32734

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131 A

Registration No. G32734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BEARON REINFORCED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: So. Balto. Gen. Hosp. 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Leadenhall St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Dye

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace No. Carolina (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Ind Balto Filling Sta

FATHER
12. Name Anthony Dye
13. Birthplace No. Carolina

MOTHER
14. Maiden Name Nancy Storey
15. Birthplace N. C.

16 (a) Informant Mollie Howard
(b) Address 937 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Social L Brown & Son
(b) Address 108 W Montgomery St

19 (a) (b) Registrar
Date received by registrar SEP 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 24 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 18, 1945 to SEPT 24 1945 and that I last saw him alive on SEPT. 24, 1945

Duration
Immediate cause of death UREMIA
Due to CARDIO-VASCULAR-RENAL DISEASE
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: SEPT. 24, 1945

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Ehrlich M. D.
Address 1213 Light St Date signed 9-25-45

Huntington Williams, M.D.

G32735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32735 / 161A

Registered No. G32735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 W Conway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 542 W Conway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Infant McCarey

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-45

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name George McCary
13. Birthplace S.C.

MOTHER
14. Maiden Name Annie Mae Youngs
15. Birthplace S.C.

16 (a) Informant George McCary (7)
(b) Address 542 W Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 28 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 101 W Montgomery St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar
SEP 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23- 1945 to 9-25- 1945, and that I last saw him alive on 9-25- 1945.

Immediate cause of death Congenital Atelectasis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R H Jackson
Address 6014 Arlington Ave Date signed 9-26-45 (M. D.)

G32736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1194

G32736 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINTED RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division st.

(c) Hospital or institution Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 22

(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos, 12 d.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 606 West Conway st

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mayourtia Harrington.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race Negro.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/13/45

8. AGE: Years | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Maryland.

(Town, county, and state)

10. Usual Occupation infant.

11. Industry or business

MOTHER / FATHER

12. Name Mayor Harrington.

13. Birthplace Baltimore, Maryland.

14. Maiden Name Viola Winfield.

15. Birthplace Prince Georges, Virginia

16 (a) Informant Viola Winfield

(b) Address 606 W. Conway st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28 1945 (month) (day) (year)

(c) Cemetery or crematory Mount Auburn

Location Baltimore City.

18 (a) Funeral director Joseph A. Loverly

(b) Address 1700 N. Mount street

19 (a) Date received by Registrar SEP 28 1945 (b)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1945, at 3:45 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/24 1945 to 9/25 1945 and that I last saw h[illegible] alive on 9/25 1945

Immediate cause of death

Dehydration from Acidosis

Due to diarrhea

Due to dehydration.

Other Conditions Malnutrition, rickets, anemia, enteritis, pneumonia,

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ralph W. Rackley M.D.

Address 420 N. Howard Date signed 9/26/45

G32737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G32737 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5201 Cardiff Avenue
(c) Hospital or institution:
26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Cardiff Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM EDWARD HEIM

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	none	M	W	Married

6 (b) Name of husband or wife Minnie A. Hartman Heim
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Street Cleaner
11. Industry or business Baltimore City

FATHER
12. Name Frederick Heim
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Reese
15. Birthplace Maryland

16 (a) Informant Mrs. Minnie Heim -Widow
(b) Address 5201 Cardiff Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-45 (month) (day) (year)
(c) Cemetery or crematory St. Pauls
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received by Registrar SEP 28 1945 (b) Registrar Huntington Mill, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 4.43 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to Sept 26 1945, and that I last saw him alive on Sept 25 1945.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease, Chr. hypertension.	
Due to Carcinoma of Cecum, Metastatic Jaundice	6-16-45 / 9-2-45
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. Eschenmuth M. D.
Address 842 E. Eager Ave. Date signed 9-26-45

G32738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1194

Registered No. G32738

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd Street
(b) Street address 3813 Woodlawn Ave
(c) Hospital or institution: Union Memorial Hospital, Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Woodlawn Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

n-1

3 (a) FULL NAME Boss Carlton Shaw

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 16 1945

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation 0
11. Industry or business

FATHER
12. Name Louis H. Shaw
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Olive Lockland
15. Birthplace Pennsylvania

16 (a) Informant mother
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Forkwood
Location Balto. Co. Md.

18 (a) Funeral director Leo H. Fiels
(b) Address 2700 Edmondson Ave

19 (a) SEP 18 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1945 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/1945, to 9/17/1945, and that I last saw him alive on 9/17/1945.

Immediate cause of death Cardiac failure

Due to Pneumonia

Due to Pleurisy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Shaw M. D.
Address Date signed 9/21/45

X

G32739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32739

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 E. Cumberland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 E. Cumberland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Attman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sylvia —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Widow
11. Industry or business

FATHER
12. Name Meyer Attman
13. Birthplace Russia

MOTHER
14. Maiden Name Faga Linda —
15. Birthplace Russia

16 (a) Informant Family
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St
(c) Huntington Williams Mgr

SEP 28 1945
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-45 19 , at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3rd 1945 to Sept 27 1945
and that I last saw him alive on Sept 27 1945

Immediate cause of death Arteriosclerotic disease with heart failure. — Duration

Due to Senility

Due to

Other Conditions Cachexia.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Merrill J. Fine M. D.
Address 118 Dixquith St Date signed 9/28/45

VS 150

X 115 C

G32740 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G32740

CERTIFICATE OF DEATH

1. PLACE OF DEATH Presbyterian Hospital ✓ Registered No. 412
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1017 E. Baltimore St. Ward)

Length of residence in city or town where death occurred 8 yrs. 6 mos. 26 da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Ruth Waldsmith Balto. Co. If U. S. Veteran specify WAR ...

(a) Residence: No. 201 Tracy Rd St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a. If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 7/30/37

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
8 yrs	1	26	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School Girl
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) 201 Tracy Rd Balto Co Md

FATHER
13. NAME Carl F. Waldsmith
14. BIRTHPLACE (city or town) (State or country) Bloom Pa.

MOTHER
15. MAIDEN NAME Frieda Erdmyer
16. BIRTHPLACE (city or town) (State or country) Scranton Pa.

17. INFORMANT J. A. Moncure
(Address) 1017 E Baltimore St

18. BURIAL, CREMATION, OR REMOVAL
Place Moreland Memorial Date Sept 29 1945

19. UNDERTAKER John D Connelly
(Address) 4101 Eastern Ave. Balto 24

20. FILED SEP 28 1945 19 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/25 1945

22. I HEREBY CERTIFY, That I attended deceased from Sept 25 1945 to Sept 25 1945
I last saw him alive on Sept 25 1945. Death is said to have occurred on the date stated above, at 11:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
I (a) Hemorrhage of Lungs	
Thrombosis Left Pulmonary Artery	
Adenocarcinoma of Lungs	
Other contributory causes of importance:	
Pulmonary Embolism	

Was an operation performed? Yes Date of ... 9-25-45
For what disease or injury? Thrombosis Pulmonary Embolism
Name of operation Tracheotomy Date of 9/25/45
What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...
Where did injury occur? ... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place ...
Manner of injury ...
Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) J. A. Moncure M. D.
(Address) 1017 E Baltimore St

Moncure

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 9

G32741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93D

G32741 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3026 PRESSTMAN STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) 28 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE CITY
(c) City or town BALTIMORE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 PRESSTMAN STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LERA ZIMMERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	WHITE	MARRIED

6 (b) Name of husband or wife WALTER C. ZIMMERMAN
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) April 15, 1887

8. AGE: Years	Months	Days	If less than one day
58	5	12	____ hr. ____ min.

9. Birthplace WALKERSVILLE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRANKLIN D. HARSHMAN
13. Birthplace WALKERSVILLE, MD.

MOTHER
14. Maiden Name LYNNE DINTERMAN
15. Birthplace WALKERSVILLE, MD.

16 (a) Informant DAVID F. ENGLAR, JR.
(b) Address 3323 LIBERTY HEIGHTS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Sun. 9/30/45 (month) (day) (year)
(c) Cemetery or crematory MT. HOPE, WOODSBORO, MD
Location

18 (a) Funeral director G. C. BARTON
(b) Address WALKERSVILLE, MD.

19 (a) (b)

SEP 28 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH THURS., Sept. 27 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1945, to Sept. 27 1945, and that I last saw her alive on Sept. 27 1945.

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE & PARALYSIS	1 day
Due to ADVANCED ARTERIOSCLEROSIS	?
HYPERTENSION --about	?
Due to	
Other Conditions CARDIO VASCULAR DISEASE	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Dublett M. D.
Address 2220 GARRISON BLVD. Date signed 9/28/45

X

G32742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

G32742
Registration No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5239 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5239 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua E. Parks

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Edna V. McCormick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1853

8. AGE: Years	Months	Days	If less than one day
92	2	21	hr. min.

9. Birthplace Tomonna, Md.
(Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business -1

FATHER
12. Name Elias K. Parks
13. Birthplace Unknown.

MOTHER
14. Maiden Name Ruth Anderson
15. Birthplace Unknown

16 (a) Informant Harry F. Parks.
(b) Address 5239 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loring Byers.
(b) Address 5005 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

vs SEP 28 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1945, at 2:20 A. M

21. I certify that death occurred on the date stated; that I attended deceased from 19..., and that I last saw him alive on 9/25 1945.

Immediate cause of death
Cardiac asthenia
Due to Pneumonia
Due to Lung Edema
Due to Arteriosclerosis

Duration
several days
Weeks
Hours

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh Russell
Address 3902 Fernhurst Dr. Date signed 9/27/45 M.D.

G32743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 137a

G32743 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 BARCLAY St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WALTER S. NEAL SR.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Widowed

6 (b) Name of ~~husband or~~ wife Hattie N. Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1875

8. AGE: Years	Months	Days	If less than one day
70 80	0	1	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation House Painter
11. Industry or business

FATHER
12. Name WILLIAM NEAL
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name MARY JANE Stephenson
15. Birthplace BALTIMORE, MD.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto, Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b) Huntington Williams, M.D. Registrar

SEP 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1945, at 3:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1945 to Sept 25 1945. and that I last saw HIM alive on Sept 25 1945.

Immediate cause of death	Duration
Myocardial Failure	6 hrs.
Due to Arterio Sclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 25, 1945
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy: Benign Prostatic Hypertrophy Infarcts Lung Spleen

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee III, M.D.
Address Union Memorial Hospital Date signed 9/25/45

G32744 Herz

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

G32744 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore #12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Evesham Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Marie Herz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Phillip Herz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1920

8. AGE: Years 25 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Machine operator

11. Industry or business Unknown

FATHER
12. Name Howard Willey
13. Birthplace Maryland

MOTHER
14. Maiden Name Francis Ulzey
15. Birthplace Maryland

16 (a) Informant WILLIAM P. HERZ (HUSBAND)
(b) Address 618 RAPPOLLA ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE? EXT.

18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 S. WOLFE ST.

19 (a) SEP 28 1945 (Date received by Registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1945, at 9 13/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1945 to 9/27 1945 and that I last saw her alive on 9/27 1945

Immediate cause of death: Malignancy — Duration: Jan-45

Due to: Krukenberg Tumor — Jan-45

Due to: Unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan-45

Major findings of operation: Malignancy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. H. Nelson Jr
Address Mercy Hosp. Date signed 9/27/45

X Stedii

632745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51D

632745 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2243 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Cora M. Stein
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Apr. 7. 1859

8. AGE: Years 86 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Jeweler
11. Industry or business

FATHER 12. Name Henry Stein
13. Birthplace Germany

MOTHER 14. Maiden Name Helena Hammel
15. Birthplace Germany

16 (a) Informant Cora M. Stein
(b) Address 2243 W. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Nels. John W. Teufel Son
(b) Address 801 W. Lafayette St

19 (a) Date received by Registrar SEP 28 1945 (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1944 to 9/27 1945 and that I last saw h alive on 9/27 1945

Immediate cause of death Carcinoma of penis — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyman Kelly M. D.
Address 30 Wilkens Date signed 9/27/45

X cert

G32746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G32746 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ABOVE SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Louden & Madison

(c) Hospital or institution: Maryland General Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 mo 7 day

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 2818 Winchester St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: BEULAH KATHERINE HAHN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Robert F. Hahn

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 13, 1894

8. AGE: Years: 51 | Months: 1 | Days: 15 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER — 12. Name: George J. Hiltner

13. Birthplace: Balto., Md.

MOTHER — 14. Maiden Name: Maggie Redding

15. Birthplace: Manchester, Md.

16 (a) Informant: Mr. Robert F. Hahn

(b) Address: 2818 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS

(b) Address: Baltimore, Md.

(a) (b) Registrar

SEP 28 1945

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-28-45 19 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 19 45 to 9/28 19 45 and that I last saw h alive on 19

Immediate cause of death: Cachexia

Due to: Carcinoma of breast & metastasis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Carcinoma of breast

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Gerard E. Brown M. D.

Address: Md. General Hospital Date signed 9/28/45

VS 150

G32747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32747 Registered No. 83 A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 N. Longwood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Miller Teaney

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife John W. Teaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6. 1875

8. AGE: Years	Months	Days	If less than one day
69	11	21	hr. min.

9. Birthplace Blacksburg Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James W. Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Mary E. Staiger
15. Birthplace Blacksburg Va.

16 (a) Informant Mrs Belle B Tindle
(b) Address 2327 Longwood st

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-28-45 (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Warwick C. Va.

18 (a) Funeral director Wm. J. Tickner
(b) Address North & Pa. ave Balto. Md.

SEP 28 1945 (a) Date received by registrar (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 10 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed Sept. 28-45

Per: Howard J. Madden, M. D.

Dr. Joseph Blum
1206 E. Preston St.

G32748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

Registered No. G32748

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 Ensor Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 Ensor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH POWERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Joseph F. Powers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1858

8. AGE: Years	Months	Days	If less than one day
87	--	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Young
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Thomas Donohue
(b) Address 1423 Ensor Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/43 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

SEP 28 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27th, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1945 to 9/27 1945 and that I last saw her alive on 9/26 1945

Immediate cause of death Gangrene (Left foot) — Duration 5 days
Due to Thrombosis Saphenous Vein — 5 day
Due to Arteriosclerosis — ?
Other Conditions Chronic Arthritis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 1206 E. Preston St. Signed 9/27/45

97

G32749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58B

Registered No. G32749

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 N. Curley Street
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Curley Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund John Urban

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20, 1927

8. AGE: Years	Months	Days	If less than one day
17 yrs.	10	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER
12. Name Edward Urban
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna K. Havranek
15. Birthplace Baltimore, Md.

16 (a) Informant Parents
(b) Address 800 N. Curley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

SEP 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1945, to Sept. 27 1945, and that I last saw h~~im~~ alive on 9/26 1945

Immediate cause of death acute myocardial insufficiency — Duration 3 hrs.

Due to rheumatic endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Schlicht

Address 4474 N. Kenwood Ave Date signed 9/26/45 M. D.

VS 150

G32750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183 A

Registered No. G32750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 E. Eager Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Caulk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Samuel Caulk (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1885

8. AGE: Years	Months	Days	If less than one day
60 yrs.	2	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Allen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Caroline Kornmann
15. Birthplace Bermany

16 (a) Informant Mrs. Elizabeth A. Anderson (dght)
(b) Address 2413 E. Eager Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 SEP 28 1945 Hunsicker for Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1945, at 6.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1942, to Sept. 25 1945 and that I last saw her alive on Sept. 25 1945.

Immediate cause of death Cerebral hemorrhage — Duration 4 days

Due to Hypertension Arteriosclerosis — Duration about 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Klimas M.D.
Address 2623 E. Monument Date signed 9/26/45

VS 150

G32751

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G32751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E 33rd St.
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Hampden ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sidney Charles Bagg

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-07-0915A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Mrs. Sidney C. Bagg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1876

8. AGE: Years	Months	Days	If less than one day
68	11	17	hr. min.

9. Birthplace London, England (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Mr. Robert Bagg
13. Birthplace England

MOTHER
14. Maiden Name Ellen Reed
15. Birthplace England

16 (a) Informant Widow (Mrs. Millie C. Bagg)
(b) Address 2807 Hampden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-1945 (month) (day) (year)
(c) Cemetery or crematory Meadowridge.
Location Howard Co. Md.

18 (a) Funeral director Sherwood Mortuary Co. of Woodlawn.
(b) Address

19 SEP 28 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945 at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Sept 28 1945 and that I last saw him alive on Sept 26 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
accident	
Due to Arteriosclerosis	
Other Conditions Arteriosclerosis	
heart Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 9/28/45 M. D.

VS 130

G32752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83A

Registered No. G32752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Hawthorne
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Hawthorne (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Gertrude Diffendeffer

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Chas. M. Diffendeffer
6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): July 2 1881

8. AGE: Years 64 | Months 2 | Days 25 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: Edw. D. Crook
13. Birthplace: Illinois

MOTHER
14. Maiden Name: Grace Tonner
15. Birthplace: Baltimore

16 (a) Informant: Chas. M. Diffendeffer husband
(b) Address: 212 Hawthorne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 29 45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville

18 (a) Funeral director: Sherwood Mason Co.
(b) Address: 108 W Mt Royal Av

19 (a) SEP 28 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 - 1945 at 2 - M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 26 1945, and that I last saw h[illegible] alive on Sept 26 1945.

Immediate cause of death: Cerebral Hemorrhage
Due to: Hypertension
Arterio Sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Walter A. Baetjer M. D.
Address 115 St Paul St Date signed 9/27/45

VS 180

Walter A. Baetjer

G32753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G32753

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. University Parkway, Balto 18
(If rural give location)
(e) Citizen of foreign country? Was yes (Yes or No)
If yes, name country Canada

3 (a) FULL NAME Miss Cora May Ostie

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-6-1884

8. AGE: Years	Months	Days	If less than one day
61	1	22	hr. min.

9. Birthplace Ontario, Canada
(Town, county, and state)
10. Usual Occupation Registered Nurse
11. Industry or business

FATHER
12. Name Wesley D. Ostie
13. Birthplace Milton-Halton Co., Ontario, Canada

MOTHER
14. Maiden Name Margaret Jane Clark
15. Birthplace Greenock-Bruce Co., Ontario, Canada

16 (a) Informant Miss Lillian R. Reifsnider (friend)
(b) Address 106 W. University Pkwy, City

17 (a) Burial (b) Date thereof Sept. 29 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Douglas Hill Cemetery
Location Walkerton, Ontario, Canada

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City

19 (a) SEP 28 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1945, at 4 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1945 to Sept 28 1945 and that I last saw her alive on Sept. 27 1945

Immediate cause of death	Duration
Metastatic carcinoma of breast	16 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Jarrett III M. D.
Address Union Memorial Hospital Date signed 9-29-45

G32754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G32754 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 COLD SPRING LANE
(c) Hospital or Institution: COLD SPRING NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 WKS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH FORREST

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife WILLIAM
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JULY 12-1860

8. AGE: Years	Months	Days	If less than one day
85	2	15	hr. ✓ min. ✓

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business ✓

FATHER
12. Name WILLIAM SCHELHOUSE
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA -UNKNOWN-
15. Birthplace GERMANY

16 (a) Informant ROBERT AND JOHN FORREST
(b) Address 2544 EDMONDSON AVENUE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 29-45 (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location EDMONDSON AVENUE

18 (a) Funeral director C. CHESTER WEBER
(b) Address 2503 EDMONDSON AVE.

19 (a) Date received SEP 28 1945 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to Sept 27 1945, and that I last saw her alive on Sept 18 1945.

Immediate cause of death: Valvular heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. N. Cattermen
Address 7324 Reisterstown Rd Date signed 9/28/45

VS 180

G32755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G32755 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1930 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Childress

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Arthur R. Childress
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 23rd 1898
8. AGE: Years 46 | Months 9 | Days 3 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at home

FATHER
12. Name Edward Olmer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Estella Albers
15. Birthplace Md.

16 (a) Informant Mr Arthur R. Childress
(b) Address 1930 Edmondson Ave
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/26/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cath. Cem.
Location 5700 Edgewood Road
18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Hollins St
19 (a) (b) Washington-Williamsport, Md.

SEP 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26th 1945 at 3.15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Sept 26 1945
and that I last saw her alive on Sept 26 19 45
Immediate cause of death Carcinoma of Breast (with metastasis to Lungs Liver and Glands)

	Duration
Due to	6 Mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. A. Lally M. D.
Address 3517 Edmondson Ave Date signed Sept 28, 1945

VS 190

Book - 4 29285

G32756

G32756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V1197

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton & Madison Ave
(c) Hospital or institution:
Md. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Mc Henry St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Barbara Ann Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife 2-26-44

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	2	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Robert Willis

13. Birthplace Va.

MOTHER 14. Maiden Name Kathryn Walker

15. Birthplace Va.

16 (a) Informant Mother

(b) Address 925 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/45 (month) (day) (year)

(c) Cemetery or crematory Mountain View Cem

Location Oregon, Md.

18 (a) Funeral director John T. Corcoran & Son

(b) Address 901 Hollins St.

1945 SEP 28 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Sept 27 1945, and that I last saw h alive on Sept. 27 1945.

Immediate cause of death	Duration
Acidosis	3 days
Due to dehydration	
Due to diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Shelby M. D.
Address Md. Gen'l Hosp Date signed 9/27/45

VS 8

G32757

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32757 Registered No. 1639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1166 Cleveland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Mc Donnell

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1921

8. AGE: Years	Months	Days	If less than one day
24	4	27	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Soldier
11. Industry or business U.S. Marines

FATHER
12. Name Michael J. McDonnell
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Wothelinga Kotnair
15. Birthplace Baltic Md

16 (a) Informant Wothelinga Kotnair
(b) Address 1166 Cleveland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary Cem
Location 4309 Old Frederick Rd.

18 (a) Funeral director Henry Conway & Son
(b) Address 90 W. Fayette St.

19 (a) SEP 28 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 7:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Sodium Fluoride Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 28 1945 A.M.
(b) Where did injury occur? 1166 Cleveland St.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work Home
(d) Means of injury Took Sodium Fluoride
23. Signature Robert Lee Fisher M.D. Medical Examiner.
Date signed Sept. 28 1945

VS 151

G32758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 55E

Registered No. G32758

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PERSON ASSIGNED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or Institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Glenmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane. Theresa Curreri THERESA CURRERI-

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Carmelo Curreri
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 8/14/90

8. AGE: Years	Months	Days	If less than one day
55	1	24	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Salvatore Cimino
13. Birthplace Italy

MOTHER
14. Maiden Name Agostina Di Stefano
15. Birthplace Italy

16 (a) Informant Carmelo Curreri (Husband)
(b) Address 2918 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) SEP 28 1945 Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/45 19 at 7:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/45 19 to 9/28/45 and that I last saw her alive on 9/26/45

Immediate cause of death Cardio-respiratory failure

Due to Adenocarcinoma Cardia-

Due to Metastasis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-26-45

Major findings of operation: Adenocarcinoma Cardia with metastasis

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. B. Hagen M. D.
Address St. Joseph's Hosp. Date signed 9/28/45

G32759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 463

G32759

Registered No. 63714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Park Drive
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Buffalo (If outside city or town limits, write RURAL and give town)
(d) Street No. 95 E. Gennessee Street (If rural give location)
(e) Citizen of foreign country? Naturalized 1918 (Yes or No)
If yes, name country

3 (a) FULL NAME Nils Nilsen

3 (b) If veteran, name war

3 (c) Social Security Account No. 106-14-1530

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1883

8. AGE: Years	Months	Days	If less than one day
62	9	25	hr. min.

9. Birthplace Christiansen, Norway (Town, county, and state)
10. Usual Occupation Bos'n
11. Industry or business Seafaring

MOTHER / FATHER

12. Name Nils Nilsen
13. Birthplace Christiansen, Norway
14. Maiden Name Nansime ?
15. Birthplace Christiansen, Norway

16 (a) Informant RECORDS- U.S.Marine Hospital
(b) Address Baltimore 11, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 29 45 (month) (day) (year)
(c) Cemetery or crematory Location Buffalo N.Y.

18 (a) Funeral director Oller Funeral Home Inc
(b) Address 4647 Liberty Heights Ave, Balto, Md

SEP 28 1945 (Date filed by Registrar)

Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 26 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1945 to Sept 26 1945, and that I last saw him alive on Sept. 26 1945.

Immediate cause of death Peritonitis, Regional Acute — Duration 9 days

Due to (Post operation-Gastrectomy for Adenocarcinoma of Stomach)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation September 18, 1945

Major findings of operation: Gastrectomy, subtotal

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson M. D.

Address U.S. Marine Hospital Date signed 9/27/45

VS 180

X

G32760 Bochniak

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1194

Registered No. G32760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 South Ann St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Charles Bochniak

3 (b) If veteran, name war: D | 3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/45

8. AGE: Years	Months	Days	If less than one day
		18	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Bochniak
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bertha Riggins
15. Birthplace Balto Md

16 (a) Informant Bertha Bochniak
(b) Address 16 Jeffrey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cath
Location Balto Md
18 (a) Funeral director A. Howard Evans
(b) Address 1400 Lombard St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1945, to Sept. 27 1945, and that I last saw h[illegible] alive on 9/27/45 19

Immediate cause of death Respiratory failure

Due to acute intestinal diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation D

Major findings of operation: D

of autopsy: D

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Streeter
Address Union Memorial Hosp Date signed 9/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

SEP 28 1945

X

G32761 BORK G32761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkers v Centre
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (~~year~~ days) 10
(e) Length of stay in Baltimore (~~year~~ days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Berea Harford Co. Md
(If rural, give location)
(e) Citizen of foreign country? NC (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Estella Bork

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: CHAS BORK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 10, 1878

8. AGE: Years 66 Months 10 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER
12. Name Henry Greene
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Estelmire
15. Birthplace Maryland

16 (a) Informant Sister Irene Greene
(b) Address Berea Harford Co. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1, 45 (month) (day) (year)
(c) Cemetery or crematory Loyal Rest Md.
Location St Johns

18 (a) Funeral director Ida E Gross
(b) Address Berea Md.

19 SEP 29 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1945 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1945 to 9-28 1945
and that I last saw h.e.r. alive on 9-28 1945

Immediate cause of death Cardiac Failure

Due to Arteriosclerosis Fa-adenocarcinoma Ovary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Funeral Ltd Baltimore

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D'Alia M.D.

Address St Agnes Hosp Date signed 9/29/45

SANKS

G32762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ B1A

Registered No. G32762

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 Mc Culloh St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Anne R. Sanks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm Sanks

6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) April - 1840

8. AGE: Years 55 | Months 5 | Days — | If less than one day hr. min.

9. Birthplace Norfolk, Va (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Alice W. Hall
(b) Address 2037 Mc Culloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-45 (month) (day) (year)
(c) Cemetery or crematory Antrim
Location Balto. Co.

18 (a) Funeral director Samuel M. Sullivan Jr.
(b) Address 117 N. Eamsdell Ave

19 (a) Date received SEP 29 1945 (b) Registrar Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1945 at 7 57 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945, to 9-28-1945 and that I last saw her alive on 9-28-1945.

Immediate cause of death	Duration
hypostatic bronchopneumonia	48 hrs
Due to cerebral hemorrhage	16 days
Due to hypertensive cardiovas.	
Other Conditions Cardiac - renal disease	3 yrs

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James D. Carr, M.D.
Address 56 Scholar St Date signed 9-28-45

G32763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32763

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct spelling. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3400 Cedardale Road

(c) Hospital or institution: * * *

(d) Length of stay in hospital or inst. (yrs., mos., or days) *

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3400 Cedardale Road.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Leonard J. Lubbehusen

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-2226

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Margaret E. Lubbehusen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th. 1886

8. AGE: Years	Months	Days	If less than one day
59	1	20	hr. min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual Occupation Vice Pres. Calvert Bank

11. Industry or business

FATHER 12. Name Joseph Lubbehausen

13. Birthplace Baltimore

MOTHER 14. Maiden Name Blanche Knott

15. Birthplace Baltimore.

16 (a) Informant V. Blanche Lubbehusen

(b) Address 3400 Cedardale Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Road

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt. Royal Ave.

19 (a) Sept 29 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 6-40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1945, to Sept 27 1945, that I last saw h[illegible] alive on Sept 27 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Pulmonary Edema	4 days
Due to Hypertensive Cardiovascular disease	20 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. J. Sullivan

Address 2911 Barrister Blvd Date signed 9-28-45

31328

G32764

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 95B

G32764
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D. C
(If outside city or town limits, write RURAL and give town)
(d) Street No. 562 Le Baum Pl S. E.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadore Bleiberg

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-09-5412

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sara Bleiberg
SAYA WIENPY 6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9-13-1904

8. AGE: Years	Months	Days	If less than one day
41	0	12	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation News paper man
11. Industry or business

FATHER
12. Name Mayer Bleiberg
13. Birthplace Austria

MOTHER
14. Maiden Name Esther Yoseu
15. Birthplace Austria

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/45 (month) (day) (year)
(c) Cemetery or crematory Lombardy Cemy.
Location Wilmington, Del.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar

SEP 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1945 at 4 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1945 to 9-25 1945 and that I last saw him alive on 9-25 1945.

Immediate cause of death Congestive Heart Failure
Pulmonary Infarction
Due to Rheumatic Heart Disease

Duration: at least 2 yrs

Due to

Other Conditions Azotemia
? Lobular Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Brockman M.D.
M. D.
Address Johns Hopkins Hosp Balto, Md. Date signed 9/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 C

Registered No. 032765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 33rd Street
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo 12 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Sewickley Penn (If outside city or town limits, write RURAL and give town)
(d) Street No Little Sewickley Creek Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MARTIN CHRISTIAN PFAHLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 087-05-1115

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Martha Leich Pfahler

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 17 1907

8. AGE: Years	Months	Days	If less than one day
38	8	12 11	____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name HARRIS W. PFAHLER
13. Birthplace Massachusetts

MOTHER
14. Maiden Name PEARL CHASE
15. Birthplace Massachusetts

16 (a) Informant Wife
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29 41 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Evansville Indiana

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) SEP 29 1945 Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1945 to Sept 28 1945 and that I last saw him alive on Sept 28 1945

Immediate cause of death Testicular Carcinoma with metastasis — Duration

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation 6-20-45 Biopsy by Major findings of operation: Metastatic carcinoma of testis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Hopper, III, M.D.
Address Union Memorial Hospital Date signed 9/19/45

VS 150

6332766

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 A

6332766
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 N. Carey St
(c) Hospital or institution: 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 706 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Susie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Norfolk Co, Va (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name William Smith

13. Birthplace Norfolk Va

MOTHER 14. Maiden Name Cindi Gordon

15. Birthplace Norfolk Co, Va

16 (a) Informant Susie Smith

(b) Address 706 N. Carey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-45 (month) (day) (year)

(c) Cemetery or crematory Norfolk, Virginia
Location Virginia

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) (b)
(Signature of local registrar)

SEP 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1945 at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1945 to 9/27 1945 and that I last saw [illegible] alive on 9/27/45

Immediate cause of death

Duration

Due to Cerebral Hemorrhage

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Leong M.D.

Address 113 Hanlon Date signed 9/28/45

G32767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32767 / 36 / 1243

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore City 4-3 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Brunt St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John Spratley

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth Goodrum
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Mar. 17, 1895
8. AGE: Years: 50 Months: 6 Days: 9 If less than one day: hr. ..... min.
9. Birthplace: Cape Charles, Virginia (town, county, and state)
10. Usual Occupation: Porter
11. Industry or business .....

FATHER
12. Name: John Spratley
13. Birthplace: Cape Charles Va.

MOTHER
14. Maiden Name: Julia
15. Birthplace: Cape Charles Va.

16 (a) Informant: Mrs. Ruth Spratley
(b) Address: 1828 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-45 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Memorial
Location .....

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) SEP 29 1945 (Date received by Registrar) (b) ..... Registrar.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1945; 3:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection on and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cirrhosis of Liver

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature [illegible] M.D. Medical Examiner.
Date signed 9/27/45

VS 151

G32768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32768 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Fulton & Caton
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Charles F. Griebe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth E. Griebe.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13 - 1885

8. AGE: Years 60 | Months 1 | Days 14 | (If less than one day) hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Restauranteur.

11. Industry or business

FATHER 12. Name Frederick Griebe.
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Schneider.
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth E. Griebe.
(b) Address 801 - Hollins St.

17 (a) Burial. (b) Date thereof Oct. 1 - 45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 SEP 29 1945 (b) Huntington Mills Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1945 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1945 to 9/27 1945, and that I last saw h[illegible] alive on 9/27 1945.

Immediate cause of death	Duration
Pulmonary embolism	
Due to Amputation of right leg	
Due to ~~Diabetes~~ Diabetic gangrene	
Other Conditions Gas gangrene of stump	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Dry Gangrene

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Chandler
Address St Agnes Hosp Date signed 9/29/45 M. D.

G32769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G32769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Goldstrom ✓

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) March 17, 1863

8. AGE: Years	Months	Days	If less than one day
82	6	10	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Goldstrom
13. Birthplace Prussia

MOTHER
14. Maiden Name Rena Brummer,
15. Birthplace Prussia

16 (a) Informant Mrs. M. Goldstrom
(b) Address Temple Garden Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Baird Sondheim Lee
(b) Address 1902 Eutaw Place

19 (a) (Local registrar) (b) Huntington Williams M.D. (Registrar)

SEP 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1945 to 9/27 1945 and that I last saw him alive on 9/27 1945

Cause	Duration
Immediate cause of death Pneumonia	
Due to	
Due to	over
Other Conditions Prostatic obstruction, Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Hamburger M. D.
Address Sinai Hospital Date signed 9/27/45

X

G32770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G32770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Emersonian Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eli Strouse

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-9928

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie W. Strouse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1871

8. AGE: Years 74 | Months 4 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation V. Pres. B.V.D. Co.

11. Industry or business

FATHER
12. Name Isaac Strouse,
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah Strauss,
15. Birthplace Germany

16 (a) Informant Mrs. Eli Strouse
(b) Address Emersonian Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/45 (month) (day) (year)
(c) Cemetery Oheb Shalom
Location Balto. Md.

18 (a) Funeral director David Sondheim & Son
(b) Address 190 E. Eutaw Place

19 SEP 29 1945 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1945 to 9/28 1945. and that I last saw him alive on 3:25 AM 9/28/45

Immediate cause of death Uremia — Duration

Due to Benign prostatic hypertrophy

Due to

Other Conditions Hypertension, arteriosclerosis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Hamburger M. D.
Address Date signed 9/29/45

VS 150

137A

G32771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32771 Registered No. 83A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eastern Avenue
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 South Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Harrison Jackson
13. Birthplace Cambridge Md

MOTHER 14. Maiden Name Francis Levy
15. Birthplace Cambridge Md

16 (a) Informant Emma Jackson (wife)
(b) Address 315 E. Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1st 45 (month) (day) (year)
(c) Cemetery or crematory Bethel Meth. Cemetery
Location Baltimore Md

18 (a) Funeral director Thos. E. Wilson
(b) Address 1000 E. Broadway

19 (a) (b) Thursday for Williamsport, Md.
(Date and hour of burial)

SEP 29 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/45 19 at 12:55 P.M.

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Spontaneous Subarachnoid Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 9/28/45

ALSTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 2772 (032772)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 0A

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Durham
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROGER ALSTON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	W.

6 (b) Name of husband or wife: Annie Alston
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Littleton, N. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Alston
13. Birthplace N C

MOTHER
14. Maiden Name Lucil Alston
15. Birthplace N C

16 (a) Informant Andrew Alston (Bro.)
(b) Address 416 N Ann St

17 (a) Burial (b) Date thereof Sept 30th 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Brooklyn Md

18 (a) Funeral director Clory O Wilson
(b) Address 1000 Pennsylvania Ave

19 (a) (Signature) (b) Washington, D.C. Registrar
SEP 29 1945

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/45 19 , at 457p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said ~~Autopsy~~, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward, M.D.
Medical Examiner.
Date signed 9/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32773 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner's Woodland
(c) Hospital or institution West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Crain Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David S. Lear Jr.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Anna M. Lear
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1910

8. AGE: Years	Months	Days	If less than one day
35	4	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Gas & Electric

FATHER
12. Name David S. Lear
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Amelia Freeburger
15. Birthplace Philadelphia, Pa.

16 (a) Informant Mrs. Anna M. Lear
(b) Address 517 Crain Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1945, to Sept 28 1945, and that I last saw h[illegible] alive on Sept 28 1945

Immediate cause of death	Duration
Ruptured pulmonary	
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: All 5 lobes examined - Coronary dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Baldwin
Address West Baltimore General Hospital Date signed 9/28/45

G32774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8/13 D

G32774
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto. Street
(c) Hospital or institution:
1526 Ford Baltimore Hotel
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Dist. Col. (b) County -
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Q Street N. W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank P. Bratten

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Flo E. Bratten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1885

8. AGE: Years	Months	Days	If less than one day
59	8	29	hr. min.

9. Birthplace Pocomoke City, Md.
(Town, county, and state)
10. Usual Occupation Chief Inspector State License
11. Industry or business Bureau of Maryland

FATHER
12. Name William F. Bratten
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Flo E. Bratten
(b) Address 2500 Q St., Wash., D. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory
Location Pocomoke City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 29 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26- 1945, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection of Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions Diabetic Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecio M.D.
Medical Examiner.
Date signed 9-28-45

VS 151

G32775 ✓ G32775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2645 Beryl Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2645 Beryl Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Constantie Podles

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Maria
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Store keeper
11. Industry or business Self

FATHER
12. Name Joseph Podles
13. Birthplace Poland

MOTHER
14. Maiden Name Rezalia Zyska
15. Birthplace Poland

16 (a) Informant Maria Podles
(b) Address 2645 Beryl Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Date received by registrar SEP 29 1945 Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 15 1945 to Sept 27 1945. and that I last saw h alive on Sept 27 1945.

Immediate cause of death	Duration
Angina Pectoris	ca 6 mos
Due to coronary occlusion	
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Frank A Januszeski M. D.
Address 2429 Fait Ave Date signed 9/28/45

Januszeski ×

VS 150

AB-88178 G32776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32776 ✓ 13 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.-4mos-5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Elm Tree St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella Vykoukal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Rudolph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15- 1912

8. AGE: Years	Months	Days	If less than one day
33	4	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Skuska
13. Birthplace Ukraine

MOTHER
14. Maiden Name Tina Popius
15. Birthplace Ukraine

16. (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (b) Registrar

SEP 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-28- 19 45, at 7.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23- 19 45 to 9-28- 19 45 and that I last saw h.er alive on 9-28- 19 45.

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert B. Rylander Jr. M. D.
Address Balto. City Hosp. Date signed 9/28/45

Huntington Williamsport, Md.

G32777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G32777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & Calhoun Sts

(c) Hospital or institution: Franklin Square Hosp. 13-7

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. Wyman Park Apts Beech ave & 39th St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred Kroeber (Frederick W. Kroeber, Jr.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife ---

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---

8. AGE: Years	Months	Days	If less than one day
About 51	---	---	-- hr. --- min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Asst. Mgr. Burglar Dept.

11. Industry or business Md. Casualty Co.

FATHER

12. Name Fred Kroeber

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Emma Kayler

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Chas. D. Sapp

(b) Address 1503 Argonne Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert Street

SEP 29 1945 (Date received by Registrar) (b) Huntington Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-45 19 , at 10:59 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 45 to 9-27-1945, and that I last saw h i M alive on 9-27-1945.

Immediate cause of death	Duration
Cachexia	
Due to Ca of stomach	10 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. K. Kroeber M. D.

Address Franklin Square Hosp. Date signed 9-28-45

Dr. Brennan
5217 Harford Road
G32778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G32778

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 Gorsuch Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Gorsuch Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James J. Riley

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-9624-A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary J. Riley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1878

8. AGE: Years	Months	Days	If less than one day
67	6	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Patrick Riley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mooney
15. Birthplace Ireland

16 (a) Informant Mrs. Mary J. Riley
(b) Address 1511 Gorsuch Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 SEP 29 1945 (Date rec'd by registrar) (b) Huntington Hollins

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 26 1945 and that I last saw h[illegible] alive on Sept 26 1945

Immediate cause of death Cardiac failure

Due to Coronary Thrombosis

Due to Arteriosclerosis

Other Conditions Uremia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan, M.D.
Address 5217 Harford Rd Date signed 9-28-45

VS 150

G32779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registration No. G32779

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER + Dukeland Sts
(c) Hospital or institution:
West Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice C. Lyons Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-45

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Maurice C. Lyons Sr.
13. Birthplace Bushnell, Ill.

MOTHER
14. Maiden Name Gladys M. Pennington
15. Birthplace Kentucky

16 (a) Informant Maurice C Lyons
(b) Address 3018 Herbert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. Northern

19 SEP 29 1945 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945 to 9-29 1945 and that I last saw him alive on 9-29 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Malnutrition

Due to and Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Burkhardt M. D.
Address West Baltimore Gen'l Hosp Date signed 9/29/45

G32780

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G32780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Edgevale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Tschudi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Jessie May Fleming Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1866

8. AGE: Years	Months	Days	If less than one day
79	6	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Vice Pres Bank

FATHER
12. Name William M. Tschudi
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Jemerny
15. Birthplace Maryland

16 (a) Informant Harold Tschudi
(b) Address 504 Edgevale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.29.45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry A. Wittstadt
(b) Address 411 E Edmondson Ave.

SEP 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945; at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1945 to 9/29 1945, and that I last saw h[illegible] alive on 9/29 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic C. V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 9/29/45

VS 150

G32781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 W. 33 St (11)
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Brent Hedrick

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business none

FATHER
12. Name Harry Irvin Hedrick
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hilda Vita Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hilda Hedrick
(b) Address 508 W. 33 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem
Location Balto Md. (Hampden)

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615 Chestnut Ave

Sep 29 1945 Huntington Williamsport Md
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945, at 1.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1945 to 9-29 1945, and that I last saw him alive on 9-29 1945

Immediate cause of death Respiratory failure — Duration 1 day

Due to

Due to

Other Conditions Premature (2lb 12oz)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9/29/45

G32782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95-13 G32782 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Albemarle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Misabile
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Demo (Catherine) Misabile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1913

8. AGE: Years	Months	Days	If less than one day
31 32	10	15	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Bar tender
11. Industry or business

FATHER
12. Name Anthony Misabile
13. Birthplace Italy

MOTHER
14. Maiden Name Sarah Misabile
15. Birthplace Italy

16 (a) Informant Demo (Catherine) Misabile
(b) Address 116 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1st/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Grauh Della Voce
(b) Address 52 N. Morley St.

19 (a) 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1945, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945, to 9/28 1945, and that I last saw him alive on 9/28 1945.

Immediate cause of death Heart Failure — Duration

Due to Old Rheumatic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Bailey M. D.
Address Mercy Hospital Date signed 9/29/45

G32783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

G32783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Colora
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of ~~husband~~ or wife Lizzie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jessie Adams
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Nancy Barlow
15. Birthplace N. Carolina

16 (a) Informant Univ. Hosp.
(b) Address Redwood & Green

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 45 (month) (day) (year)
(c) Cemetery or crematory West Cutting Ham
Location Colora Md.

18 (a) Funeral director J. E. Tyson
(b) Address Reisterstown Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1945 to Sept 29 1945, and that I last saw him alive on Sept 29 1945.

	Duration
Immediate cause of death Uremia	
Due to Urinary retention	
Due to Cystitis following Transurethral Resection	
Other Conditions Peritonitis prostatic hypertrophy. (Include pregnancy within 3 months of death)	
Date of operation Sept 17	
Major findings of operation: Necrosis of prostate following TVP	
of autopsy: cystitis, peritonitis, hydro-ureter	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence Wiseman M. D.
Address Univ. Hosp. Date signed 9-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

SEP 30 1945

3788 G32784

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G32784 Registered No.

CERTIFICATE OF DEATH 133a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Caroline Co.
(c) City or town Marydel
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary Thomas
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) 9-21-1913

8. AGE: Years	Months	Days	If less than one day
32 31	-	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cleaner
11. Industry or business

FATHER
12. Name Jacob Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Myrtle Thomas
15. Birthplace Delaware

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct. 4, 45 (month) (day) (year)
(c) Cemetery or crematory Greenbrier
Location Hyattsville Md.

18 (a) Funeral director R. B. Rawlings
(b) Address Greensboro Md.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1945, at 4 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1945 to 9-29 1945; and that I last saw h alive on 9-29 1945.

Immediate cause of death Uremia — Duration 1 WK

Due to Renal failure — ?

Due to

Other Conditions Hyper tension, Arteriolosclerosis
(Include pregnancy within 3 months of death)

Date of operation 6/15/45

Major findings of operation: Nephrectomy Left, Pyelonephritis, atrophy.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. O'Donohue M. D.
Address Johns Hopkins Hosp Date signed 9-29-45

SEP 30 1945

X

G32785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G32785 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Mt. Royal Ave., Balto-17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James P. McClurg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-1880

8. AGE: Years	Months	Days	If less than one day
64	10 8	18	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name James McClurg
13. Birthplace Penna.

MOTHER
14. Maiden Name Elizabeth Grier
15. Birthplace Penna.

16 (a) Informant Mr. Edwards Wells
(b) Address Northway Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3 1945 (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Odd Fellows Pa.

18 (a) Funeral director E. P. Rogers
(b) Address Odd Fellows Pa.

19 (a) (Date rec'd by registrar) (b)

SEP 30 1945

Huntington Hilliard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945, at 11 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1945 to 9/29 1945 and that I last saw h/m alive on 9/29 1945

Immediate cause of death: Heart failure.

Due to: Coronary thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Stadtman M.D.

Address Mercy Hosp. Date signed 9/29/45

X

G32786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32786 ✓ 108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Bradley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Bradley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Annie Helen Torian

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1924

8. AGE: Years	Months	Days	If less than one day
20	11		hr. min.

9. Birthplace Roxborough, D. C. (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER — 12. Name	Anderson Torian
FATHER — 13. Birthplace	North Carolina
MOTHER — 14. Maiden Name	Mary Calley
MOTHER — 15. Birthplace	North Carolina

16 (a) Informant Pauline Moore
(b) Address 522 Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 9-30-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Sept. 27, 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 10 1945 to Sep 26 1945, and that I last saw h[illegible] alive on Sep 26 1945.

Immediate cause of death	Duration
Lobar Pneumonia	16 dys
Due to	
Due to Exposure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Wolters M. D.
Address 1443 E. Eager Date signed 9-27-45

VS 150

X

G32787 G32787

363437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La. (b) County
(c) City or town Lake Providence (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Frank Gordon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Jane Newsome Gordon
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) 4-29-1919

8. AGE: Years	Months	Days	If less than one day
26	5	-	hr. min.

9. Birthplace Tenn. (Town, county, and state)
10. Usual Occupation student
11. Industry or business

FATHER 12. Name William Gordon
FATHER 13. Birthplace Ill.
MOTHER 14. Maiden Name Sara Goodston
MOTHER 15. Birthplace Tenn

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-45 (month) (day) (year)
(c) Cemetery or crematory GREENVILLE, MISS.
Location

18 (a) Funeral director Jack Fowler Inc
(b) Address 1739 E. Balto. St.

19 (a) (Date rec'd by registrar) (b)

SEP 30 1945

Huntington Williams, Md

acoustic

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21- 1945 to 9-29- 1945 and that I last saw h alive on 9-29- 1945

Immediate cause of death Brain tumor - a Diffuse neurinoma - post operative.
Due to Post operative a Diffuse neurinoma.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9-22-45
Major findings of operation: Brain tumor - left acoustic neurinoma
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lew Q. Williams
Address Lew Q. Williams Asst Balto. Md. Date signed 9/29/45

X

G32788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

118

G32788

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution: South Balto Gen Hosp. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)

(d) Street No. 121 E WEST ST.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MAY HARLE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	215-12-0026	FEM.	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 8-1907

8. AGE: Years	Months	Days	If less than one day
38	7	20	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation OFFICE WORK.

11. Industry or business

FATHER

12. Name BERNARD C HARLE

13. Birthplace BALTIMORE MD

MOTHER

14. Maiden Name ELLA V. WHITE

15. Birthplace MARYLAND

16 (a) Informant Bernard C Harle

(b) Address 121 E WEST ST.

17 (a) BURIAL (b) Date thereof Oct 2-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS CEM

Location A.A. Co.

18 (a) Funeral director Joseph Hausmaker Sons

(b) Address 60 W Washington Blvd

19 (a) (b) Registrar.
(Date rec'd by registrar)

SEP 30 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945 to Sept 28 1945, and that I last saw h alive on Sept. 28 1945.

Immediate cause of death Asphyxiation of blood

Due to Gastric Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Thos. E. Wheeler M.D.

Address South Balto. Gen. Date signed 9/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

G32789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G32789

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette (John's) St.
(c) Hospital or institution Hospital for Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town Huntington (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Penn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie B. Johann.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Divorced

6 (b) Name of husband or wife Charles Johann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-72

8. AGE: Years	Months	Days	If less than one day
72	9	22	hr. min.

9. Birthplace Huntington PA. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Lester
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Lester (Mohrs)
15. Birthplace Germany

16 (a) Informant Mrs Ida Miller
(b) Address 406 Penn St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/30/45 (month) (day) (year)
(c) Cemetery or crematory
Location Huntington Pa.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received by registrar) (b) Registrar

SEP 30 1945

VS 180

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/45 19 45 at 10:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26/45 19 , to 9/29/45 19 , and that I last saw h[illegible] alive on 9/27 19 45.

Immediate cause of death	Duration
Cardiac Respiratory failure	2 days
Due to Carcinoma Stomach.	(1)
Due to - following surgical procedure	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/26/45
Major findings of operations: Carcinoma Stomach
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Paliza MD
Address Hospital for Women of Md Date signed 9/29/45 M. D.

G32790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G32790

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 FAIT AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 [redacted] Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. KRICHTON

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-2160

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 29, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	0	hr. min.

9. Birthplace BALTO. MD. (Town, county, and state)
10. Usual Occupation MNGR.
11. Industry or business AMUSEMENT CENTER.

FATHER
12. Name JOSEPH F. KRICHTON
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ANASTASIA BARRANGER
15. Birthplace BALTO. MD.

16 (a) Informant SARAH FISHER (SISTER)
(b) Address 3803 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD CEM.
Location TAYLOR AVE. PARKVILLE.

18 (a) Funeral director Charles B. Zeiler
(b) Address 3605 FAIT AVE.

19 (a) 9-30-1945 (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 29 1945, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 9/29 1945, and that I last saw h IM alive on 9/28/1945.

Immediate cause of death	Duration
Chronic myocarditis	
Chronic nephritis	
Due to Hypertension	
arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Joseph Fourney M.D.
Address 441 S. Ellwood Ave. Date signed 9/29/45

VS 189

X

G32791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G32791 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 329 S. LEHIGH ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Lehigh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. BOSS

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-10-4555

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	WIDOWED

6 (b) Name of husband or wife ROSE BOSS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 23, 1872

8. AGE: Years	Months	Days	If less than one day
72	10 9	5	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation BLACKSMITH
11. Industry or business BETHLEHEM-KEY HGHWY.

FATHER
12. Name ? BOSS
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant James White (Daughter)
(b) Address 1850 Ellwood Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-1 45. (month) (day) (year)
(c) Cemetery or crematory SACRED HEART Cem
Location GERMAN HILL RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 FAIT AVE.

19 (a) SEP 30 1945 (Date rec'd by registrar) (b) Huntington Hill Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 28, 1945 at 10.39 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 19 to Sept 28 1945, and that I last saw h[im] alive on Sept 26 1945

Immediate cause of death	Duration
(1) Coronary Thrombosis	
(2) or Cerebral Apoplexy.	
Due to Hypertensive C.V. dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Greenfield M.D.
Address 161 E. Eager St Baltimore Md Date signed 9/29/45

VS 180

EDWARD N. MINCHER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G32792 Registered No. G32792

G32792

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2127 Druid Park Drive (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Edward N. Mincher

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife: —

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 18-1945

8. AGE: Years	Months	Days	If less than one day
—	1	11	hr. min.

9. Birthplace: Mercy Hosp., Balt., Md. (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business:

FATHER — 12. Name: Edward Joseph Mincher
13. Birthplace: Maryland

MOTHER — 14. Maiden Name: Lorraine L. Jones
15. Birthplace: Maryland

16 (a) Informant: Edward J. Mincher
(b) Address: 2127 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 2-1945 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

SEP 30 1945 (Registrar's date) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/29 1945, at 5:03 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1945, to 9/29 1945, and that I last saw h[illegible] alive on 9/29 1945.

Immediate cause of death: Epidemic diarrhea of the newborn — Duration: 5 wks.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robert Mark, M. D.
Address: Univ. Hosp. Date signed: 9/29/45

H 1 G32793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G32793

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2455 Brentwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2455 Brentwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gladys Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1901

8. AGE: Years	Months	Days	If less than one day
44	11	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Williams Blue
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Katherine ?
15. Birthplace Balto Md.

16 (a) Informant James Byrd
(b) Address 2455 Brentwood Ave

17 (a) Burial (b) Date thereof Sept 30 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County Md.

18 (a) Funeral director Mrs Edgar H. Edwards
(b) Address 1129 N. Carlins Ave

19 (a) (b) Washington Williams Registrar

Sep 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 19 45 at 3.45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 - 19 45 to Sept 27 19 45, and that I last saw h alive on Sept 27 19 45.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. O. Johnson

Address 2529 Guilford Ave Date signed Sept 29 1945

Registered
Mail to Funeral Director

BALTIMORE CITY HEALTH DEPARTMENT V G32794
CERTIFICATE OF DEATH 45E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Inc. Kean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac H. Hicks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Jn. Hicks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 17 - 1858

8. AGE: Years	Months	Days	If less than one day hr.	min.
87	8	11		

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Williams Jefferson Hicks
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Florence Jn. Hicks
(b) Address 1129 Inc. Kean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cem.
Location Balto. Co. Md.

18 (a) Funeral director Ingalls Cook Byer
(b) Address 1600 W. North Ave.

19 (a) SEP 30 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 3:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1945, to Sept. 28 1945, and that I last saw him alive on Sept. 27 1945.

Immediate cause of death	Duration
Cerebral Embolism	1 Month
Due to Arteriosclerotic Cardio-Vascular Disease	Unknown
Due to Senility	
Other Conditions Carcinoma of Breast with Chronic Osteomyelitis of Rt. Mandible	

(Include pregnancy within 3 months of death)

Date of operation Sept. 22, 1945

Major findings of operation: Chronic osteomyelitis of Rt. mandible

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin A. Johnson M. D.
Address Univ. Hospital Date signed 9/28/45

G32795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32795 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Springdale ave & Eldorado
(c) Hospital or institution: Va. Lewis Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Erdman ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Schlutter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 - 1869

8. AGE: Years	Months	Days	If less than one day
76.	4.	16.	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Hardware Mfg.
11. Industry or business Retired

FATHER
12. Name John G. Schlutter
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna
15. Birthplace Germany

16 (a) Informant Mrs. Charles Schlutter
(b) Address 2220 Erdman ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-1945 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mausoleum
Location Baltimore Md

18 (a) Funeral director Maurice Bork Leyfer
(b) Address 1600 W. North ave

19 (a) SEP 30 1945 (Date rec'd by registrar) (b) Huntington-Williams, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28: 1945, at 8-22 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept 28 1945 and that I last saw him alive Sept 22 1945

Immediate cause of death
Due to Cerebral Hemorrhage
Due to Generalized Arteriosclerosis
Other Conditions Senile Ectasia of Aorta

(Include pregnancy within 3 months of death)

Duration: 3 mos

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Rothschild M. D.
Address 730 N. Eutaw Date signed Sept 29 1945

G32796 — Cannon — G32796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2043 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman H. Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No. 224-18-1001

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Jan 5-1913

8. AGE: Years	Months	Days	If less than one day
32	8	25	hr. min.

9. Birthplace Cambridge Md (Town, county, and state)
10. Usual Occupation Trucker
11. Industry or business Gulf Oil Co.

FATHER
12. Name Corey Cannon
13. Birthplace Madison Md.

MOTHER
14. Maiden Name Katie Slocum
15. Birthplace Taylors Island Md

16 (a) Informant Margaret Cannon
(b) Address 2043 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-45 (month) (day) (year)
(c) Cemetery or crematory Green Sayon
Location Cambridge Md.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2455 E. Oliver St.

(a) SEP 30 1945 Registrar (b) Huntingtown Maryland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1945 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1945 to 9/30 1945; and that I last saw him alive on 9/26 1945.

Immediate cause of death	Duration
PERITONITIS	
Due to PERFORATED APPENDICITIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: PERFORATED APPENDICITIS - PERITONITIS
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Morton Stratz M. D.
Address St. Agnes Date signed 9/30/45

VS 150

G32797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G32797 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 S Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 S Kenwood
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Volk

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 29 1856

8. AGE: Years	Months	Days	If less than one day
89	8	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Joseph Volk
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Dachlager
15. Birthplace Germany

16 (a) Informant Fred C Schmidt
(b) Address 632 S Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 Orleans St.

19 Date received OCT 1 1945 (b) Thurlington Holbrook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1945 to Sept 28 1945, and that I last saw her alive on Sept 28 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	Sept 28/45
Left Sided Paralysis	
Due to Arterial Hypertension	
Arterio-Sclerosis	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis F Kummer M. D.
Address 722 N Kenwood Ave Date signed Sept 29/45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

36 G32798

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G32798

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lowndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8247 Long Pt. Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Helen Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-96

8. AGE: Years	Months	Days	If less than one day
49	7	23	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Martin Graham
13. Birthplace Ala.

MOTHER
14. Maiden Name Jane Jacobs
15. Birthplace Ala

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/30/45 (month) (day) (year)
(c) Cemetery or crematory
Location Birmingham, Alabama

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (b) Registered OCT 1 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1945 to Sept 29 1945 and that I last saw him alive on Sept 29 1945

Immediate cause of death: Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Grant Wilmer M. D.
Address Johns Hopkins Hosp Date signed 9/29/45

VS 150

X

G32799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G 32799 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5004 E. Preston Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Alma Amick

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Clarence Leroy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1881

8. AGE: Years 64 | Months 3 | Days 1 | If less than one day: hr. min.

9. Birthplace Alamance Co. N. Car.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name William Staley
13. Birthplace N. Car.

MOTHER
14. Maiden Name Tempa May
15. Birthplace N. Car.

16 (a) Informant William B. Parks
(b) Address 5004 E. Preston St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 30, 45 (month) (day) (year)
(c) Cemetery or crematory Asheboro
Location Asheboro, N. Car.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 OCT 1 - 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945 at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 45 to Sept 30 1945 and that I last saw him alive on Sept 30 1945

Immediate cause of death: Carcinoma of breast — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conal Hinton M.D.
Address 220 W. North Ave Date signed 9-30-45

G32800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 472

Registered No. G32800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Harlem Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Black

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Elizabeth Black
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13 1883

8. AGE: Years	Months	Days	If less than one day hr.	min.
62	1	16		

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Alexander Black
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Todd
15. Birthplace Scotland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Dulaney Valley

18 (a) Funeral director George G. Farley
(b) Address Fulton & Fayette

19 OCT 1 1945 (Date received by Registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1945 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1945, to Sept. 29, 1945 and that I last saw h[illegible] alive on Sept. 29, 1945.

	Duration
Immediate cause of death Pulmonary edema + pleural effusion a respiratory failure	2-3 weeks
Due to Lupus erythematosis	?
Due to	
Other Conditions Laryngectomy for Ca. of Larynx	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Ca. glands of neck + Trachea, Lung [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature David F. Bell, Jr. M. D.
Address Date signed

VS 150

G32801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32801 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Adona Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elanor G Perkins

3 (b) If veteran, name war NV

3 (c) Social Security Account No. unk

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Everett C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1888

8. AGE: Years 57 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Oklahoma Ok. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas E Purcell

13. Birthplace Va.

MOTHER 14. Maiden Name Lucy Motherhead

15. Birthplace Va.

16 (a) Informant Everett C Perkins

(b) Address 906 Adona Rd Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Baltimore Co Md

18 (a) Funeral director Wilhelm Roth Inc

(b) Address 1217 E Pratt St

Date rec'd OCT 1 1945 (by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945 at 9:32 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Sept 28 1945 and that I last saw h w alive on Sept 28 1945

Immediate cause of death — Duration

Pulmonary Tuberculosis — ?

Due to

Due to Tuberculosis of spine — about 15 mo.

Tuberculous of bladder about 1 mo.

Other Conditions Tuberculor glands of neck — about 6 mo

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Walter L Tibbitt M. D.

Address 2220 Garrison Blvd Date signed

VS 150

G32802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G32802

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ERRORS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Forgotten Calhoun
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2952 Presstman st (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Margaretta Miller

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife: Henry Miller
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1853

8. AGE: Years	Months	Days	If less than one day
92	1	6	hr. min.

9. Birthplace: Balto., Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Wolfgang Krauss
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine Frichtel
15. Birthplace: Germany

16 (a) Informant: Mr. Charles J. Miller
(b) Address: 2952 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

OCT 1 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1945 to 9-28 1945, and that I last saw her alive on 9-25 1945

Immediate cause of death	Duration
Senile debility - Arterio Sclerotic Cardio Vascular	Decomp
Due to Post traumatic encapsulation & dilapidation	
Due to Fractured neck of rt femur.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-14-45 at 1617 M
(c) Where did injury occur? home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury fall

23. Signature H. K. Keyserman M. D.
Address Franklin Square Hosp Date signed 9-28

VS 150

Approved: Robert Lee Graham M.D.

G32803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G32803

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1845 N. Spring st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 N. Spring st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard D. Dupree

3 (b) ~~If veteran, name war~~

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-45

8. AGE: Years | Months | Days: 25 | If less than one day: hr. min.

9. Birthplace 1845 N. Spring st.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Minnie Dupree
15. Birthplace South Carolina

16 (a) Informant Minnie Dupree
(b) Address 1845 N. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Robt. E. Williams
(b) Address 1515 Mc Elderry St.

19 (a) OCT 1 1945 (Date rec'd by Registrar) (b) Registrar

VS 3

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29-45 19 , at 12¾ M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5-45 19 , to 9-29-45 19 , and that I last saw h alive on 9-29-45 19 .

Immediate cause of death Respiratory Insufficiency

Due to Phlebotomia

Due to

Other Conditions Diabetes .
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred E. Warren M. D.
Address 2340 Whitelock Date signed 9-29-45

161a

G32804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32804 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 LUCILE AVE (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME ISRAEL GILDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name SAMUEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name ANNA
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-1-45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location DENNEL ST

18 (a) Funeral director Jake Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) Huntington Woods Baltimore, Md.

OCT 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/45 19 , at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1945, to 9/28 1945, and that I last saw him alive on 9/28 1945.

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertension - Arteriosclerotic heart Dis.	
Due to	
Other Conditions Pertinent Cancer Benign Prostatic Hypertrophy (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan D. Rhode M. D.
Address Sinai Hosp Date signed 9/29/45

X

032805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 032805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 S. Robinson Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 S. Robinson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Walter Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-4103

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife PELAGIA Tillie Wisniewski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Grinder

11. Industry or business H.C. Weiskittel Co

FATHER
12. Name Joseph Wisniewski
13. Birthplace ?

MOTHER
14. Maiden Name Josephine ?
15. Birthplace ?

16 (a) Informant Tillie Wisniewski
(b) Address 428 S. Robinson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George R. Weber
(b) Address 705 South Ann Street

19 (a) Date received by local registrar OCT 1 1945 (b) Huntington Willis Reed, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28th 1945 at 11, 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945, to Sept 28 1945, and that I last saw him alive on Sept 28 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Acute Pulmonary Edema	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B. Wolfe

Address 1331 E. North Ave Date signed 9-29-45

X

G32806 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G32806

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Garrison Blvd St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Anna Siegel

If U. S. Veteran specify WAR

(a) Residence: No. 2914 Garrison Blvd St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Harry Siegel

6. DATE OF BIRTH (month, day, year) 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) ~~Ger~~ Poltz

FATHER

13. NAME Isaac Siegel

14. BIRTHPLACE (city or town) (State or country) Poltz

MOTHER

15. MAIDEN NAME Elka —

16. BIRTHPLACE (city or town) (State or country) Poltz

17. INFORMANT Harry Siegel (Address) 2914 Harrison Blvd

18. BURIAL, CREMATION, OR REMOVAL Place Rosedale Date 10-1-45, 19

19. UNDERTAKER Jack Levin Inc (Address) 1739 E. Baltimore St

FILED OCT 1 - 1945, 19 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 30, 1945

22. I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1945 to Sept. 30, 1945.

I last saw h[er] alive on Sept 29, 1945. Death is said to have occurred on the date stated above, at 1[0] p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	
Other contributory causes of importance: Hemiplegia	1937.

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Samuel B Moffie, M. D.

(Address) 1331 E North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 8

X

G32807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G32807

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5801 CLOVER RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5801 CLOVER RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB SHULMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name SAMUEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name GITTLE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 10-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Philo Rd & Hamilton Ave

18 (a) Funeral director Jack Lazar Inc
(b) Address 1439 E. Balt St

19 (a) Stuttington Williams M.D.
(Date received by Registrar) Registrar

OCT 1 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-45 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/18 1942 to 9/28 1945 and that I last saw h[illegible] alive on 9/25 1945.

Immediate cause of death	Duration
Ca Coronary Thrombosis	
Due to ch coronary sclerosis	
Due to ch myocarditis	
Other Conditions dt diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Stonesifer M. D.
Address 733 Argonne Dr Date signed 9/30/45

93D

G32808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8118 E. Gough Street Exact
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harvey Joseph Kuessner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-3574

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Yolanda
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Dec. 16. 1914

8. AGE: Years	Months	Days	If less than one day
30	9	12	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Rudolf Kuessner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Dorsch
15. Birthplace ?

16 (a) Informant Yolanda Kuessner
(b) Address 8118 E Gough St. East

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2/45 (month) (day) (year)
(c) Cemetery or crematory Mont Holy Redeemer
Location Belair Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Monument Ave

19 (a) 1-1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945, at 10 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1945, to 9/28 1945, and that I last saw him alive on 9/28 1945.

Immediate cause of death	Duration
Pneumonia, bilateral	
Due to Intoxication ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin D. Rude M. D.
Address Date signed 9/29

VS 150

G32809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G32809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3631 Kimble Road
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3631 Kimble Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE LEE HOWE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Walter Howe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	14	hr. min.

9. Birthplace Chincoteague Island, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Melvin
13. Birthplace Va.

MOTHER
14. Maiden Name ? Robbins
15. Birthplace Va.

16 (a) Informant Mrs. Helen I. Pollock
(b) Address 3631 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10- 1-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

OCT 1 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945, to Sept 28 1945, and that I last saw her alive on Sept 27 1945.

Immediate cause of death Mitral and Myocardial ins. sufficiency hypertension. chr. Nephritis

Due to

Due to

Other Conditions Acute dilatation of heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Sneed M. D.
Address #316 Med. Arts Bldg Date signed Sept 29, 45

VS 190

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

The G32810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G32810

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Fleet St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rose Hoyt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edw A Hoyt

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar 29 1889

8. AGE: Years 56 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Anthony Kastelek
13. Birthplace Austria

MOTHER
14. Maiden Name Katherine Strnad
15. Birthplace Austria

16 (a) Informant Edw Hoyt
(b) Address 3113 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 45 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ellicott Funeral Home
(b) Address 2008 Orleans St

19 OCT 1 - 1945 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945 to Sept 28 1945, and that I last saw her alive on Sept 28 1945.

	Duration	
Immediate cause of death Pulmonary Edema	9/27/45	
Due to Hyp. Pancreatic Neoplasm	5/1945	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Rzasek M.D.
Address 601 N. Rendon Rd Date signed 9/29/45

VS 150

G32811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G32811 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Brendan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Brendan Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Zeiger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Otto W. Zeiger
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 8-15-1886

8. AGE: Years	Months	Days	If less than one day
59	1	13	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emil Eis
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Otto W. Zeiger
(b) Address 2811 Brendan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brockman
(b) Address 900 N. Chester St

19 (a) 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D. Medical Examiner.
Date signed 9-29-45

G32812

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4002 Belle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Belle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H. HUTTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1862

8. AGE: Years	Months	Days	If less than one day
83	0	12	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Electrical Engineer (retired)
11. Industry or business (30 yrs.)

FATHER
12. Name George H. Hutton
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Mildred Blackburn
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Giralda Monk
(b) Address 4002 Belle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1945, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27-1945 to 9-29-1945 and that I last saw him alive on 9-28-1945

Immediate cause of death	Duration
Acute uremia	9-29-45
Due to Arteriosclerotic cardio-renal disease	Two years
Due to	
Other Conditions Chronic arthritis deformans	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. B. Sybert M. D.
Address 2803 Harford Rd Date signed 9-29-45

Huntington Williams, M.D.

X

632813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

632813 1860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 Ridgehill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Engelhart C. Fisher

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Peters Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1884

8. AGE: Years	Months	Days	If less than one day
61	1	1	hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Balto. Brick Co.

FATHER
12. Name Franklin E. Fisher
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name - Boose
15. Birthplace Md.

16 (a) Informant Mrs. Sarah Peters Fisher
(b) Address 2000 Ridgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 - 1945 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Back, Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 25 1945 26/4 M.
(b) Where did injury occur? Balto. Brick Co 3681 E. Monument St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fall from roof

23. Signature Robert A. Foster M.D. Medical Examiner.
Date signed 9-29-45

G32814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G32814 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 Carswell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 Carswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT HUNTER McCOMAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mabel Louise McComas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business Price Construction Co.

FATHER
12. Name John McComas
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Mary Norris
15. Birthplace Md.

16 (a) Informant Mrs. Charles R. Young
(b) Address 1534 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

0611 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Sept 28 1945; and that I last saw h[illegible] alive on Sept 28 1945

Immediate cause of death	Duration
Coronary Thrombosis	7 Days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. L. Thompson M. D.
Address 9858 Harford Rd Date signed 9-30-45

X

G32815

G32815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1100a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 E. Monument St. (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country China

3 (a) FULL NAME Der Mon

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: Chinese
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Chin Shee
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: about 68 | Months: ? | Days: ? | If less than one day: hr. min.

9. Birthplace: China (Town, county, and state)
10. Usual Occupation: Laundry
11. Industry or business:

FATHER
12. Name: Der Wah Town
13. Birthplace: China

MOTHER
14. Maiden Name: Gee Shee
15. Birthplace: China

16 (a) Informant: Lum Wee Ho (nephew)
(b) Address: 4713 Eastern Ave. city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-45 (month) (day) (year)
(c) Cemetery or crematory: Loraine
Location: Woodlawn, Md.

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) OCT 2 1945 (Date rec'd by registrar) (b) Huntington Ave, Md. Registrar

VS 151

MEDICAL CERTIFICATION

15

20. DATE OF DEATH Sept. 28, 1945, at 12 p.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Ruptured Varicose Veins of Leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland E. Graham M.D. Medical Examiner.
Date signed Sept. 28 1945

G32816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G32816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 554 E. Fort Ave.
(c) Hospital or institution: 4+

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4+
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 554 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert E. Schmidt or (Edwin Albert)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Mary J. O'Neill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1882.

8. AGE: Years	Months	Days	If less than one day
63	8	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Druggist
11. Industry or business

FATHER 12. Name Christian Schmidt
13. Birthplace Germany

MOTHER 14. Maiden Name Sheltza Wolf
15. Birthplace Germany

16 (a) Informant Family
(b) Address 554 E. Fort Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore Co. Md.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.

19 (a) OCT 1 1945 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1945, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Sept 10 1945, and that I last saw h alive on Sept 10 1945

Immediate cause of death	Duration
Cerebral apoplexy.	
Due to	
Due to	
Other Conditions Arterio Sclerosis Hypertension & Diabetes (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Schmidt
Address 1337 S. Charles St Date signed 9/11/45 M.D.

83a

632817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered 632817

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 1811
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 855 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Kearney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Danny Kearney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3 1900

8. AGE: Years	Months	Days	If less than one day
44	9	24	hr. min.

9. Birthplace Richmond Virginia (Town, county and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Moe Hudson
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Julia B. Randall
15. Birthplace Richmond Va.

16 (a) Informant Elsie Garris
(b) Address 855 W. Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Dolphin St.

19 (a) (Date rec'd by local reg.) (b) Registrar

OCT 1 1945 Huntington Williams

UVS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Acute Congestive Cardiac Failure Acute Congestion of Brain, Fever Kidneys
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Mulder M.D.
Medical Examiner.
Date signed 9-28-45

G32818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 448

Registered No. G32818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1012 Edmondson Ave

(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1012 Edmondson Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Estella Carr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	widowed

6 (b) Name of husband or wife Robert C. Braxton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1868

8. AGE: Years	Months	Days	If less than one day
57	8	19	hr. min.

9. Birthplace Middlesex Co., Va. (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER

12. Name Edward Carr

13. Birthplace Middlesex Co. Va.

MOTHER

14. Maiden Name Willie Ann Ellis

15. Birthplace Middlesex Co. Va.

16 (a) Informant Ella Brooks

(b) Address 1017 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-45 (month) (day) (year)

(c) Cemetery or crematory Carlton Mem

Location Carlton

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St. Huntington Williams, Mgr.

19 (a) 9-27-45 (Date received by registrar) 448 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1945, at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1945, to Sept 27 1945, and that I last saw h alive on 19

Immediate cause of death Uterine Cancer — Duration 6 mos. 2 years

Due to — Duration

Due to — Duration

Other Conditions None — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. K. Pelterian M. D.

Address 817 Hamilton Ave Date signed Sept 29 1945

VS 150

H. K. PELTERIAN X

G32819

CWK-94368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G32819

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 5 2

(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 920 Leadenhall Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Katie Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife: Ivey Evans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/26/1919

8. AGE: Years	Months	Days	If less than one day
26	3	1	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Arthur Neely

13. Birthplace North Carolina

MOTHER

14. Maiden Name Fannie Bonnett

15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Balto Co Md

18 (a) Funeral director David L. Brown & Son

(b) Address 1028 W Montgomery St

19 (a) (Signature of registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 27 1945 at 6:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1945 to Sept. 27 1945 and that I last saw h. alive on Sept. 27 1945

Immediate cause of death Pulmonary Embolism

Due to Subinvolution & Abc. Pentonitis

Due to Subinvolution Perforation of Ileum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 3

Date of operation 9/26/45

Major findings of operation: as above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E J Perry M.D.

Address BCH Date signed 9/28/45

VS 150

1945

X

G32820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G32820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 146 N. Decker Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 146 N. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Dorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Henrietta (Jacob.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1873

8. AGE: Years	Months	Days	If less than one day
72	4	5	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Retired Laborer

11. Industry or business

FATHER
12. Name Joseph Dorn
13. Birthplace Germany

MOTHER
14. Maiden Name Stork
15. Birthplace Germany

16 (a) Informant Mrs. Henrietta Dorn
(b) Address 146 N. Decker Ave.

17 (a) Burial (b) Date thereof 10/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave.

19 (a) (b)

OCT 1 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1945, at 1.05 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inspection-Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV Disease

Due to

Other Conditions Malignant tumor of neck
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulkowski M.D.
Medical Examiner.
Date signed 9/30/45

Huntington Will Baltimore

G32821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G32821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 239 S. Duncan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 S. Duncan Street (If rural give location)
(e) Citizen of foreign country? Ger (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Karczewski
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Michalina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1871

8. AGE: Years	Months	Days	If less than one day
74	6	5	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Retd
11. Industry or business

FATHER
12. Name Henry Karczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Raimer
15. Birthplace Poland

16 (a) Informant Mrs Martha Weinknecht
(b) Address 239 S. Duncan Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 2 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b)
(Date received by Registrar) Registrar
OCT 1 1945
Huntington Millennium, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Sept 28 1945, and that I last saw him alive on Sept 28 1945.

Immediate cause of death: Cerebral Cardio-Vascular Decompensation — Duration 2 days

Due to Chr. Endocarditis, Rheumatic Heart Disease

Due to Cardiac Decompensation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anna Jeeples
Address 200 S. Patterson Park Ave Date signed 10/1/45

G32822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32822 Registered No. 14747

52 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2259 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 21/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2259 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Henry Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Clara Lee
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1893

8. AGE: Years	Months	Days	If less than one day
62	0	29	hr. min.

9. Birthplace Warrenton Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Anthony Lee
13. Birthplace Warrenton Va

MOTHER
14. Maiden Name Alice Grayson
15. Birthplace

16 (a) Informant Clara Lee
(b) Address 2259 Madison Ave

17 (a) Removal (b) Date thereof Oct. 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Fredricksburg Va

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1299 N. Caroline St.

19 (a) (Date received by registrar) OCT 1 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1944 to Sept 29 1945 and that I last saw h[illegible] alive on Sept 29 1945.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions Cancer of Urinary Bladder	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Randolph Lightstone M. D.
Address 2129 Druid Hill Ave Date signed 9/30/45

108

D. Blake
G32823

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1108

G32823
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Chatman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1892

8. AGE: Years 53 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Travers
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Harriett Jones
15. Birthplace Cambridge Md.

16 (a) Informant Roberta McGee
(b) Address 822 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) OCT 1 - 1945 (Date rec'd by registrar) (b) Registered: Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 9-28 1945.
and that I last saw her alive on 9-28 1945.

Immediate cause of death Lobar Pneumonia — Duration 10 days
Due to Bronchitis — 4 wks
Due to Exposure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas R Blake M. D.
Address 1327 N. Central Ave Date signed 9-29-45.

VS 150

BUREAU RESERVED FOR BINDING

G32824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 81a

G32824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 0. 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dudley Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1945

8. AGE: Years	Months	Days	If less than one day
	5	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry V. Brown
13. Birthplace Texas.

MOTHER
14. Maiden Name Alice Gudmore
15. Birthplace Md.

16 (a) Informant Harry V. Brown
(b) Address 1224 N. Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph S. Locke, Jr.
(b) Address 1304 N. Central Ave

OCT 1 - 1945 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1945, at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 10-1-45

VS 151

G32825 Dupl. G32825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Helton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Baltimore (If outside city limits write RURAL or name town)
(d) Street No. 3603 Oakmont Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Katherine M. Duvel.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Albert W. Duvel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24 1864

8. AGE: Years	Months	Days	If less than one day
81	8	4	hr. min.

9. Birthplace Hanover, Germany. (Town, county, and state)
10. Usual Occupation none
11. Industry or business "

FATHER 12. Name	Karl Osterlow
13. Birthplace	Germany.
MOTHER 14. Maiden Name	Unknown.
15. Birthplace	"

16 (a) Informant Miss Augusta J. Duvel
(b) Address 3603 Oakmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Lemmon Bros.
(b) Address 5005 Park Heights Ave.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28, 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 - 1942 to 9-28-1945, and that I last saw her alive on 9-28-1945.

Immediate cause of death	Duration
Cerebral hemorrhage	28 hours
Due to Hypertension	unknown
Due to Chronic Interstitial Nephritis	unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Roland, M. D.
Address 2522 Edmondson Ave Date signed 10-1-45

VS 150

X

G32826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32826 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Meredith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Agnes L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22 - 1871

8. AGE: Years 73 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace London - England
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Francis Meredith
13. Birthplace England

MOTHER
14. Maiden Name Ellen Parsons
15. Birthplace England

16 (a) Informant Mrs. Agnes L. Meredith
(b) Address 2700 Arlington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director Leonard J. Lusk
(b) Address 5805 Harford Road

19 (a) (b)

Date received by registrar OCT 1 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1945 at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1945 to 9-29 1945 and that I last saw him alive on 9-29 1945.

Immediate cause of death — Duration
Cerebral Hemorrhage
Due to Hypertensive C.V.D.
Due to
Other Conditions Prostatic Hypertrophy
Bronchial Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Joseph Hosp. Date signed 9-29-45

X

G32827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G32827 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: West Baltimore Gen Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Sturge St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Williams David Griffith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept 19 1945
8. AGE: Years | Months | Days 12 | If less than one day ____ hr. ____ min.
9. Birthplace West Balt. Gen. Hospt. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name William Ervin Griffith
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Grace Wilson
15. Birthplace Pennsylvania

16 (a) Informant
(b) Address

17 (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 1 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1945 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945 to 9/30 1945 and that I last saw him alive on 9/30 1945

Immediate cause of death UNKNOWN

Due to

Due to

Other Conditions PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: PREMATURITY. NOTHING GROSSLY

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Silberfeld M. D.
Address West Balt. Gen Hospt. Date signed 9/30/45

VS 150

2992

X

G32828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32828 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2751 Rayner Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2751 Rayner Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence J. Knight

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Janie D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1869

8. AGE: Years	Months	Days	If less than one day
76		6	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City Employee

FATHER
12. Name Geo. Knight
13. Birthplace Holland

MOTHER
14. Maiden Name Ann Shanbe
15. Birthplace 2751 Rayner Ave

16 (a) Informant Mrs. Janie D. Knight
(b) Address 2751 Rayner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudenbattle Cathedral
Location 4300 Gelston Rd
1945
(b) Address 901-03 Hollins St

(a) Williams, M.D. (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30th 1945, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944, to Sept 30 1945, and that I last saw h alive on Sept 14 1945.

Immediate cause of death	Duration: Hrs. / Months
Coronary occlusion	
Due to Chr. nephritis	3 yrs
Due to Arteriosclerosis	5 yrs
Other Conditions Had an impaired	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Williams
Address 1136 Park Ave Date signed 9/30/45 M. D.

VS-480

G32829

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1321a

Registered No. G32829

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Glyndon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Glyndon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Kral.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Frank W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1875

8. AGE: Years 70. | Months 4 | Days 18. | If less than one day hr. min.

9. Birthplace Czechoslovakia (town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name Joseph Sadilek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Mary
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Agnes Gaynor
(b) Address 2400 W. Franklin St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Road.

18 (a) Funeral director John J. Gowan Son
(b) Address 2403 Gallows St

19 (a) 1945 (Filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1944 to 9-29 1945, and that I last saw h er alive on 9/29 1945.

Immediate cause of death	Duration
a Cerebral Hemorrhage	1 da
Due to Hypertensive Cardio Vascular Renal Disease	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jorge G Lauricella M. D.
Address 1 W Washington Blvd Date signed 10/1/45

Thurlington Williams Mfg Co
Williamsport Md

632830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 632830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Wilhelm Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Wilhelm (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT F. CONDON

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-12-2072

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Minnie Condon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 - 1890

8. AGE: Years 55 | Months 2 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francis Condon
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary J Wilfley
15. Birthplace Maryland

16 (a) Informant Edna DeFrenza
(b) Address 3734 Rokeby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2 - 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

19 (a) OCT 1 - 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/45 19 , at 1 pm M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Davis Medical Examiner. M.D.
Date signed 9/30/45

VS 151

G32831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G32831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 305 Herring Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Herring Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen [redacted] HORMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1945

8. AGE: Years	Months	Days	If less than one day
	1 1/2	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Harman
13. Birthplace Bronx, N. Y.

MOTHER
14. Maiden Name Bessie Zakzaturka
15. Birthplace Bronx, New York

16 (a) Informant Joseph Harman
(b) Address 305 Herring Court

17 (a) Burial (b) Date thereof 10-2-45
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgid Rd.

18 (a) Funeral director John C Miller Inc
(b) Address 2+33-35 E. Oliver St.

19 OCT 2 — 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 19 45 at 3 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Jaquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Non Specific diarrhea
et infancy

Due to

Other Conditions
-
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Lubriande M.D.
Medical Examiner.
Date signed 10/1/45

X

G32832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G32832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5511 Belleville Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RFD, and give town)
(d) Street No. 5511 Belleville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Louise Opitz

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8 1871

8. AGE: Years 74 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John Opitz
13. Birthplace Germany

MOTHER 14. Maiden Name Lena Pfeiffer
15. Birthplace Balt Md

16 (a) Informant Annie Opitz
(b) Address 5511 Belleville Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 10/3/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Lee Co
(b) Address 1219 E Fayette St

19 OCT 2 - 1945 (b) Huntington Williams Md
(Date rec'd by Registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1945 to Sept 30 1945
and that I last saw h[illegible] alive on Sept 30 1945.

Immediate cause of death Chronic Cardio valvular disease — Duration

Due to

Due to

Other Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest H. Kalm
Address 1736 Poplar Gr Date signed 10/1/45

VS 150

G32833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

Registered No. G32833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md - General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 John St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Hendricks

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thurston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1912

8. AGE: Years	Months	Days	If less than one day
33	5	16	hr. min.

9. Birthplace New York, New York (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Carr Lowery Glass Co

FATHER
12. Name James A. Dowden
13. Birthplace Ireland

MOTHER
14. Maiden Name Helen Dowling
15. Birthplace New York, New York

16 (a) Informant Mrs. E. B. Lehman
(b) Address 3720 Fairhaven Avenue

17 (a) Burned (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Riverside
Location Norfolk, Va.

18 (a) Funeral director Wilson Cook Inc
(b) Address 1217 St Paul St

19 (a) OCT 2 - 1945 (Date rec'd by registrar) (b) Filed Washington, Williamsburg, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945 at 9:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to Carbon Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 1, 1945 M.
(b) Where did injury occur? 1618 John St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Burned in gas jets

23. Signature [illegible] M.D. Medical Examiner.
Date signed Oct 1st 1945

VS 151

G32834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G32834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: Md. General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 John St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Hendricks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1944

8. AGE: Years	Months	Days	If less than one day
1	3	28	hr. min.

9. Birthplace New York, New York (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Thurston Hendricks
13. Birthplace New York, New York

MOTHER
14. Maiden Name Anna Bowden
15. Birthplace New York, New York

16 (a) Informant Mrs. F. B. Richmond
(b) Address 3720 Fairhaven Ave. Brooklyn

17 (a) Burial, cremation, or removal (b) Date thereof 10/3/45 (month) (day) (year)
(c) Cemetery or crematory Riverside
Location Norwalk Conn.

18 (a) Funeral director Tillotson Corbin
(b) Address 1317 F Pont St.

19 OCT 2 - 1945 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1945, at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 1 1945 M.
(b) Where did injury occur? 1618 John St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Mother turned on gas

23. Signature Roland L. Fratern M.D.
Medical Examiner.
Date signed 10-1-45

G32835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G32835

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Penna. ave.
(c) Hospital or institution:

14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Penna. ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Thomas~~ Walter William Thomas Plater

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-22-1043

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1885

8. AGE: Years	Months	Days	If less than one day
60	7		hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name George Plater

13. Birthplace ?

MOTHER 14. Maiden Name Lottie

15. Birthplace Md.

16 (a) Informant Julia Mullins

(b) Address 1607 Penna Ave

17 (a) Burial (b) Date thereof 10-2-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave

19 (a) OCT 2 1945 Huntington Williams M.D.

20. DATE OF DEATH 9-28-1945; at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Masseis M.D.
Medical Examiner.

Date signed 9-28-45

US 151

X

632836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. 632836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 W 33rd. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 5

(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 W. 33rd. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Hare

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Abraham Hare

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1867

8. AGE: Years	Months	Days	If less than one day
78	5	13 14	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Micijah Shipley
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Pierce
15. Birthplace Md.

16 (a) Informant Mrs. William J. Lowman
(b) Address 601 W. 33rd. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Lee L. Beyet, Jr.
(b) Address 1512 Hollins St.

19 OCT 3 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1945, at 2:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1945 to 9/30 1945, and that I last saw h[illegible] alive on 9/29 1945.

Immediate cause of death
Hemiplegia, R.
Due to Arteriosclerosis

Duration
5 Days
yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 7020 N. Charles Date signed 10/1/45

Ex. Hillcrest
6 E. Belvedere Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 632837

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 E. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 E. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Granville W. Myers.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower.

6 (b) Name of husband or wife Mary J. Myers
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1859

8. AGE: Years 85 | Months 9 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired Laborer.

11. Industry or business

FATHER
12. Name Jacob Myers.
13. Birthplace Pennsylvania.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Henry H. Myers.
(b) Address 1804 E. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Mary's
Location Govanstown

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS OCT 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Sept 30 1945, and that I last saw him alive on Sept 30 1945

	Duration
Immediate cause of death: Cerebral Hemorrhage	6 Days
Due to: Senile Arteriosclerosis	5 years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wilbur F. Stillman M. D.
Address 6 E Belvedere Ave Date signed 10/2/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G32838

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves.

(c) Hospital or institution: St Agnes Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore 23

(If outside city or town limits, write RURAL and give town)

(d) Street No. 319 S. Fulton St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Catherine Seymer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Husband - Anton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-1896

8. AGE: Years 49 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore - Md.

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Scheuring

13. Birthplace Md.

MOTHER 14. Maiden Name Alice Boemer

15. Birthplace Md.

16 (a) Informant Anton H. W. Seymer

(b) Address 319 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1200 N. Lombard St.

19 (a) (b)

(Date rec'd by local registrar) OCT 2 - 1945 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1945, to 10-1 1945, and that I last saw her alive on 10-1 1945

	Duration
Immediate cause of death Cerebro Cardio-Respiratory Collapse	
Due to Paralytic Ileus	
Due to Repair post-operative Verdauf Hernia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/28/45

Major findings of operation: Incarcerated Omentum

of autopsy: (Yes)

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Anton H. W. Seymer Jr.

Address St. Agnes Hosp. Date signed 10/4/45 M D

X

G32839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G32839

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Nethercliff Abercrombie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Day Abercrombie
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 4, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Lawyer, retired
11. Industry or business

FATHER
12. Name John Abercrombie
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Daniels
15. Birthplace Canada

16 (a) Informant Mrs Mary Day Abercrombie
(b) Address 2528 N. Charles Sts City

17 (a) Burial (b) Date thereof Oct 2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presentation Convent
Location Harford Co. Md. Mrs Johnson

18 (a) Funeral director John O. Mitchell & Son
(b) Address 906 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945 at 11 39 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945 to Sept. 29 1945 and that I last saw him alive on Sept. 29 1945

Immediate cause of death Cerebral - vascular accident — Duration 5 Days

Due to Hypertension

Due to Arterio-sclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 9/29/45

VS OCT 2 - 1945 Huntington for Williams, M.D.

X

G32840

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1637

G32840
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ray Kietzmiller

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-42-2786

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/24/1924

8. AGE: Years	Months	Days	If less than one day
21	0	5	hr. min.

9. Birthplace Bemis, W. Va.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Edward B. Kietzmiller
13. Birthplace Oakland, Md.

MOTHER
14. Maiden Name Lyatte Leary
15. Birthplace W. Va.

16 (a) Informant Harry Shoemaker
(b) Address 3708 Pleasant St.

17 (a) Removal (b) Date thereof 10/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Elkins - I.O.O.F. Cem.
Location W. Va.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St Paul St

19 (a) (b) Registrar
(Date received by registrar) OCT 2 1945 Huntington, W. Va. Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1945, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Self inflicted Gun Shot Wound

Other Conditions Unknown

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 29, 1945
(b) Where did injury occur? 2219 Bank St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot in head with gun

23. Signature Howard J. McDevitt M.D.
Medical Examiner.
Date signed 9-29-45

G32841 X ✓ G32841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Altoona
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Logan Blvd.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Gorsuch
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Mal Gorsuch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-2-88.

8. AGE: Years	Months	Days	If less than one day
57.	3	29	hr. min.

9. Birthplace Pa.
(Town, county and state)
10. Usual Occupation Locomotive Engineer
11. Industry or business

FATHER 12. Name Ira Gorsuch.
13. Birthplace Pa.

MOTHER 14. Maiden Name Katharine Wolf
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Alto Reg
Location Altoona Pa

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 2124 Pont St

19 (a) OCT 2 1945 Thomas J. Williams, Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-1945, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1945 to 10-1-1945 and that I last saw h alive on 10-1 1945.

Immediate cause of death ? Cerebral Thrombosis — Left sided
Due to Left Subdural Hematoma — post op.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9/22/45 & 9/29/45
Major findings of operation: Subdural Hematoma — Left of Cerebral Edema.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc. Contributory
(b) Date of occurrence September, 1945 at M
(c) Where did injury occur? Pa. Ry. Altoona, Pa.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? Yes.
Engineer (Specify type of vehicle, train, streetcar, etc.) Striking Head injury
(e) Means of injury Struck by Train
23. Signature Paul Gorsuch
Address Johns Hopkins Hospital Signed 10/2/45
Baltimore, Md.

VS 150

G32842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

G32842 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 Cleveland St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Alice Fields
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1899.

8. AGE: Years	Months	Days	If less than one day
45 46	9	3	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Harry Fields.
13. Birthplace Va.

MOTHER
14. Maiden Name Alice Epps. Goode
15. Birthplace Va.

16 (a) Informant Alice Smith Fields
(b) Address 1336 Cleveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-'45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St
(c) Oct 2 1945 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1945, to Sept 28 1945, and that I last saw HIM alive on Sept 28 1945.

Immediate cause of death Surgical Shock — Duration

Due to Intestinal Obstruction from adhesions of old operative wound

Due to

Other Conditions Lobar Pneumonia (left lower lobe) & Congestion
(Include pregnancy within 3 months of death.)

Date of operation 9-28-45

Major findings of operation:

Autopsy? Multiple Intestinal Adhesions, Lobar Pneumonia, Left Base, Congestion of Lungs

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Reece R. Boone, Jr. M.D.
Address University Hosp. Date signed 9-29-45

X

G32843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

Registered No. G32843

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 E 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma A. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1869

8. AGE: Years 76 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Chesney
13. Birthplace Md.

MOTHER
14. Maiden Name Almira Griggs
15. Birthplace Md

16 (a) Informant Harry L. Martin
(b) Address 2009 E 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto. Md

18 (a) Funeral director Harry A Wiltze
(b) Address 4101 E Lanvale Ave

19 (a) Date received by registrar OCT 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Sept 29 1945. and that I last saw h[illegible] alive on Sept. 29 1945.

Immediate cause of death	Duration
Cardiac collapse	
Due to Coronary Thrombosis	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. E. Reede

Address 7314 Dr. North Th Date signed 10/1/45 M. D.

G32844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

479 Registered No. G32844

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6718 O'Donnell St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6718 O'Donnell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry J. Perzinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213.09.2540

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Perzinski
13. Birthplace Poland.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Anna Perzinski
(b) Address 6718 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Rd.

18 (a) Funeral director John J. Duda
(b) Address 2629 Hudson St

19 (a) OCT 2 - 1945 (date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to Sept 29 1945, and that I last saw him alive on Sept 28 1945.

Immediate cause of death Carcinoma of lungs.

Due to

Due to

Other Conditions Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hiram Fried M.D.
Address #316 Med. arts Bldg Date signed Sept 29/45

G32845

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47D

Registered No. G32845

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Pk. Hgts. Ave
(c) Hospital or institution: - Mt. Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 17
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 3025 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Schachter (SCHACHTER)

3 (b) If veteran, name war 1914-18

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Samuel A-
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Philip Schachter
(b) Address 3025 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory New York City, N.Y.
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1739 E. Baltimore St

19 (a) (b) Registrar
(Date rec'd by registrar) OCT 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-45 19 , at 9 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 , to 9/30 1945, and that I last saw h[illegible] alive on 9/30 1945

Immediate cause of death: Acute Cardiac failure — Duration

Due to Chr Diabetes

Due to Carcinoma of left lung.

Other Conditions: Gangrene right foot.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Weinstein M. D.
Address 733 Argyle St Date signed 10/2/45

G32846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G32846 (one)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL, and give town)

(d) Street No. 3806 Chatham Road (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ida (Siegal) Siegael

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1889 (1887)

8. AGE: Years	Months	Days	If less than one day
56	8		hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Clerical Worker

FATHER 12. Name Max Sacks

13. Birthplace Russia

MOTHER 14. Maiden Name Ada -

15. Birthplace Russia

16 (a) Informant Mrs. M. Gordon (Irvin Siegael 400 Hilton Ave)

(b) Address 2481 W. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Memorial Park

Location Baltimore Lane and Phila. Rds.

18 (a) Funeral director Jacob Heine Inc

(b) Address 1439 E. Balto. St.

19 (a) Date received by registrar (b) Registrar's No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1945, at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1945 to 9-30 1945, and that I last saw her alive on 9-30 1945

Immediate cause of death	Duration
Acute coron. occlusion anterior myocard. infarction	
Due to Hypert. + Arteriosclerosis	
Due to Heart Disease	
Other Conditions Uterine polyps. Senile Insanity. Meningioma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arnold Katz M. D.

Address Sinai Hosp. Balto. Md. Date signed 10-6-45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G32847

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

Registered No. G32847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Chilton St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Chilton St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

9-16

3 (a) FULL NAME Nettie T. Bosch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Jacob Bosch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1861

8. AGE: Years	Months	Days	If less than one day
84	4	15 16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Christian Krumm
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Angel
15. Birthplace Germany

16 (a) Informant Mrs. Julia Bosch Cunningham
(b) Address 1712 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 2 - 1945 Arlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1945, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to Sept 29 1945, and that I last saw h[illegible] alive on Sept 29 1945.

Immediate cause of death	Duration
Hiimal Pneumonia	5 days
Hypostasis	
Due to Fracture of right	May 15 to
Due to Sup. Cerebrals	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence May 15, 1945 at P. M
(c) Where did injury occur? 1712 Chilton St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs.

23. Signature [illegible] M. D.
Address 1532 E 33rd St. Date signed Oct 2 1945
Horace A. Wheeler, M.D.

G32848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G32848

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 572 Baker St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Bruce Russell Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1926

8. AGE: Years	Months	Days	If less than one day
19	4	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER

12. Name Richard Lee

13. Birthplace Richmond Co., Va.

MOTHER

14. Maiden Name Lena Veney

15. Birthplace Richmond Co., Va.

16 (a) Informant Mrs Lena Lee

(b) Address 572 Baker St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 10-2-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto, Md

18 (a) Funeral director Mrs George H. Holland

(b) Address 1631 Lemmon Hill Ave

19 (a) 1945 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945 to Sept. 28 1945. and that I last saw him alive on Sept. 28, 1945.

Immediate cause of death

Due to Pneumonia (Bilateral)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration
Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Pickens M. D.

Address Provident Hospital Date signed 9/29/45

X

G32849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1477 Registered No. G32849

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Smith
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Lena Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-16.

8. AGE: Years	Months	Days	If less than one day
29.	6	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Factory

FATHER
12. Name William Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Lyles
15. Birthplace Md.

16 (a) Informant Lena Smith
(b) Address Johns Hopkins Hospital Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. Law & A. Hall
(b) Address 1631 Druid Hill Ave.

19 (a) 1945 (Signature and address of person acting as registrar) Huntington Williams, M.D.
10-1-45

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-1945, at 8 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1945 to 10-1 1945, and that I last saw h[illegible] alive on 10-1 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia R[illegible] & R[illegible] Lobaria coma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Rowe III
Address Johns Hopkins Hosp. Md. Date signed 10/6/45

VS 150

X

G32850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32850

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 854 N Bisset St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willis Conway

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Arretta Conway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-1897

8. AGE: Years	Months	Days	If less than one day
48	5	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Caster
11. Industry or business

FATHER	12. Name Hatwillis Conway
	13. Birthplace Maryland
MOTHER	14. Maiden Name Lane Liza Gaskins
	15. Birthplace Maryland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-45 (month) (day) (year)
(c) Cemetery or crematory Quantico
Location Quantico, Md

18 (a) Funeral director Mrs Geo H Holland
(b) Address 1123 Bolton Hill Ave

19 (a) (Date received by registrar) (b) Interment in Willowbrook, Md

OCT 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1945 at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1945 to 9-29 1945 and that I last saw h[illegible] alive on 9-29 1945

Immediate cause of death: Pneumococcus Meningitis — Duration 10 days
Pneumococcus Endocarditis — 2 weeks
Due to: Type 7 pneumococcus.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen G. Vance M.D.
Address Johns Hopkins Hosp Date signed 10-2-45

X

G32851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G32851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Woodington Rd.
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTIE R. GALE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1853

8. AGE: Years	Months	Days	If less than one day
92	0	12	hr. min.

9. Birthplace Kent Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Gale
13. Birthplace Kent Co., Md.

MOTHER
14. Maiden Name Mary Enos
15. Birthplace Delaware

16 (a) Informant Miss Lydia Gale
(b) Address 606 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

OCT 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1945 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 29 1945 and that I last saw deceased alive on Sept 28 1945.

Immediate cause of death	Duration
Myocarditis	3 Mo.
Due to Cardio-Vascular Renal disease	1 yr.
Due to	
Other Conditions Epigastric Hernia	6 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. P. Van Schaick, M.D.
Address 5 Edmondson Ave
Date signed 10/1/45

Huntington Hillcrest, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G32852

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Rd.
(c) Hospital or institution: Anderson Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Chatham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY HORNER SUMWALT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John W. R. Sumwalt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1850

8. AGE: Years	Months	Days	If less than one day
94	10	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph H. Horner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Hannah E. Daneker
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Wm. H. Johnson
(b) Address 2886 Pelham Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1945, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1 1945 to 9-30 1945 and that I last saw h[illegible] alive on 9-30-1945

Immediate cause of death	Duration
Acute Congestive heart failure	1 hr
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2607 Garrison Blvd Date signed 10-1-45

VS 150 OCT 2 - 1945

X

G32853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G32853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Woodford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Woodford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM F. MILLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dora Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	7	hr. min.

9. Birthplace Littlestown, Pa. (Town, county, and state)
10. Usual Occupation Retired Sexton
11. Industry or business

FATHER
12. Name George Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Reinhart
15. Birthplace Pa.

16 (a) Informant Mrs. Dora Miller
(b) Address 402 Woodford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 2 - 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 29, 1945, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1945 to Sept. 29 1945. and that I last saw him alive on Sept. 29 1945.

	Duration
Immediate cause of death Uremia	6 days
Due to Chr. Interstitial Nephritis	5 yrs
Due to Hypertrophy Prostate	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carl H. Beuse, M.D.
Address 711 York Rd Date signed 10/1/45

Huntington Williams, M.D.

X

G32854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 E. Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife Eliza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1886

8. AGE: Years	Months	Days	If less than one day
58	-	26	hr. min.

9. Birthplace Smith Point, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Isaac Hicks
13. Birthplace Md.

MOTHER
14. Maiden Name Sydney Gray
15. Birthplace Md. Gray

16 (a) Informant Alweta Leach
(b) Address 922 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2nd 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Byron Virgin & C. Knight
(b) Address 727 Aisquith St

19 (a) Date received by Registrar OCT 2 1945 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Heredais M.D.
Medical Examiner.
Date signed 9-29-45

G32855

Temporary address: California Hall Arlington Farms U.S. Registered No. G32855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

U.S.N.R. 1105 Receiving Station, Wash. D.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mrs. Sen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Ser. 4495226
(a) State Md Va (b) County
(c) City or town Luke
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armeda W. Grove

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Theodore T. Grove
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/27/1915

8. AGE: Years	Months	Days	If less than one day
29	10	4	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation U.S.N.R.

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Navy Records
(b) Address 408 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)
(c) Cemetery or crematory
Location Luke Va

18 (a) Funeral director Oder Funeral Home Inc
(b) Address 4644 York Rd.

19 (a) OCT 2 — 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1- 1945, at 2.35 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Internal hemorrhage

Due to Laceration of lungs

Other Conditions: Fractured ribs, fractured pelvis, fractured femur, lacerations etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-1- at 2.05 A.M. 11-2
(b) Where did injury occur Monument St. x Park Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision of automobiles

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-1-45

G32856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G32856

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 S.Curley St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 S.Curley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Neal

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-8038

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Margaret Friedenwald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. George Martin
(b) Address 730 S.Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) OCT 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1945, at 2-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1945 to Sept 30 1945, and that I last saw h.. alive on Sept 30 1945

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Arterio-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.
Address 2739 Eastern Ave Date signed 10/1/45
M. D.

X

G32857 G32857 (2)

HKP #04363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1 & 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 No. Poppleton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME William Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1926

8. AGE: Years	Months	Days	If less than one day
19	1	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James Lewis
13. Birthplace Md.

MOTHER 14. Maiden Name Georgia Wilson
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto. Md.

18 (a) Funeral director Charles H Cooper
(b) Address 514 Cancellan Ave

OCT 2 - 1945 (Date rec'd by Registrar) Newton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1945 at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1945 to Sept. 29, 1945 and that I last saw him alive on Sept. 29, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Saw

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B Garland Jr M. D.
Address Balto. City Hosp. Date signed 10/1/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G32858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 497

G32858 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Bellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Bellwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Frisina

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single~~, married, widowed, or divorced: Married

6 (b) Name of husband or wife Warren Frisina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George A. Morrison
13. Birthplace Md

MOTHER 14. Maiden Name Ellen L Tinltons
15. Birthplace Va

16 (a) Informant Warren Frisina
(b) Address 4015 Bellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3rd 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo D. Lesoon
(b) Address 701-03 N. Patterson Park Ave

19 (a) (Date rec'd by registrar) (b) Registrar

C 2 vs 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28th 1945, at 4 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1943 to Sept 28 19 45.
and that I last saw h[illegible] alive on Sept 28 19 45.

Immediate cause of death: Cancerous ulcer of vulva with metastasis (generalized) — Duration: 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 10/5/45

Physician for Williams, MD

X

G32859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G32859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison Ave

(c) Hospital or institution: Md. Heine Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2409 E Oliver St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy DeFontes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business —

FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden Name —

15. Birthplace —

16 (a) Informant Mr Vandervinde

(b) Address 2409 E Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2nd 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Lee Gilcock

(b) Address 1701-03 N. Patterson Park Ave

(b) Filed by registrar Oct 2 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Sept 30 1945, and that I last saw h alive on Sept 29 1945.

Immediate cause of death	Duration
Prematurity	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Dudley Shelly M.D.

Address Md. Heine Hosp. Date signed 10/1/45

VS 150

X

G32860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G32860

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 3231 Rittenhouse (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Plant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/24

8. AGE: Years	Months	Days	If less than one day
1	5/12		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Michael Plant
13. Birthplace Md

MOTHER 14. Maiden Name Mary P Plant
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/41 (month) (day) (year)

(c) Cemetery or crematory
Location Washington D C

18 (a) Funeral director Geo M Fink & Son
(b) Address 811 N Wolfe st

19 (a) (Date rec'd by reg.) (b) Registrar

OCT 2 - 1945 Huntington Williams, M.D.

VSUdd

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Congenital Heart Anomaly — Cardiac Decompensation — Duration —

Due to: Bacterial Endocarditis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rowena Aubrey Hall Asst Res M. D.

Address Johns Hopkins Hosp Baltimore Md Date signed 10. 2. 45

X

G32861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170a

G32861
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Bass -LARKIN-

3 (b) If veteran, name war # 2. [redacted] 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Katie
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 30 1919

8. AGE: Years 26 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Shareopper
11. Industry or business Sun. Paper Co.

FATHER 12. Name James R. Bass
13. Birthplace N Carolina

MOTHER 14. Maiden Name Maggie Slaughter
15. Birthplace Va

16 (a) Informant Mr James R. Bass
(b) Address 1230 Oakend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Bell Cem.
Location 5700 Jefferson Rd

18 (a) Funeral director Joliet Conway & Son
(b) Address 901 N Fulton Ave

OCT (a) 2 — 1945 (b) [illegible] Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945 at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Congestion, traumatic

Due to

Other Conditions Fractured ribs, acute pulmonary edema
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6 A.M. at 9-29-45 12-5
(b) Where did injury occur Eastern Ave. & Kane St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? NO
(d) Means of injury Auto. into train: Driver

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 10-2-45

Thursday

X

632862

CWK-96534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195B

Registered No. 632862

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2-1916

8. AGE: Years	Months	Days	If less than one day
29	5	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bertrum Henry
13. Birthplace Virginia

MOTHER
14. Maiden Name Sue Lowery
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Emory
Location Laurel, Md.

18 (a) Funeral director Chas Stapleton
(b) Address Hampstead Md

19 OCT 2 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

Certificate to be approved by Medical Examiner
Howard J. Mc Cain, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945 to Oct. 1 1945 and that I last saw him alive on Oct. 1 1945

Immediate cause of death	Duration
surgical Shock	
Due to Fract. subtrochanteric	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-1-45

Major findings of operation:

of autopsy negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accd. 26/12
(b) Date of occurrence Oct. 1 1945 at M
(c) Where did injury occur? Baltimore City Hosp (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Fell to the floor under anesthetic

23. Signature Eugene A. Patanelli M. D.
Address Baltimore City Hosp Date signed 10-2-45

VS 150

G32863

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32863 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 N. Montford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltr. (If outside city or town limits, write RURAL and give town) N
(d) Street No. 409 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L. E. Reinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Reinhardt.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15-1863

8. AGE: Years	Months	Days	If less than one day
81	10	20	16 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Morris Reinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Eliza Herring
15. Birthplace Germany

16 (a) Informant Emma Reinhardt.
(b) Address 409 N. Montford ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3-45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave.

18 (a) Funeral director John R. Miller
(b) Address 2334 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 2 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945 at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1945 to Sept 30 1945 and that I last saw alive on Sept 30 1945

Immediate cause of death Acute Cardiac Failure — Duration 1 day
Arteriosclerotic Heart Dis — 10 yrs
Due to Kidney Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E. Monument St. Signed

10/1/45

G32864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G32864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Instr. Balt. General.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 5 - 1945

8. AGE: Years	Months	Days	If less than one day
		27	hr. min.

9. Birthplace West Balt. Gen. Hosp.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Henry Enoch Williams
13. Birthplace Alabama

MOTHER
14. Maiden Name Clara Charlotte Sorrells
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 2 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 Oct 2 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1945 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1945 to 9/1 1945, and that I last saw him alive on 9/1 1945

Immediate cause of death Prematurity.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Eberfeld M.D.
Address West Balt. Gen. Hosp. Date signed 9/4/45

VS 150

2993

G32865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 61

G32865
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812-W-35½ St.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812-W-35½ St
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian May McCauley

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jas. E. McCauley

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): March-24-1883

8. AGE: Years 62 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace: Balto. Co.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business: none

FATHER
12. Name: Ernest-Beck
13. Birthplace: Penna

MOTHER
14. Maiden Name: Sarah - ? -
15. Birthplace: Penna

16 (a) Informant: Mr. Jas. McCauley (Husband)
(b) Address: 812 W-35-St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct-4-45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn

18 (a) Funeral director: Stewart Mortuary Co.
(b) Address: 1014 W Mosher ave.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar
OCT 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1945 at 11 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1945 to 10/1 1945 and that I last saw her alive on 9/30 1945

	Duration
Immediate cause of death: Chr. Valv. heart dis.	4 yrs.
Due to: Debility	Life
Due to:	
Other Conditions: Diabetes	10 yrs

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Howard Huff M. D.
Address 2020 N. Charles Date signed 10/2/45

92D

G32866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G32866
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2. 0 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Melrose Ave - Rol. Pk.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kendrick Phillips

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elizabeth Handerty
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 10-12-1899

8. AGE: Years 45 | Months 11 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Louisville, Kentucky (Town, county, and state)
10. Usual Occupation Credit + Collection Mgr. Soc
11. Industry or business Farm Credit Adm U.S. Govt

FATHER
12. Name Charles Monroe Phillips
13. Birthplace Lebanon, Kentucky

MOTHER
14. Maiden Name Margaret Montague
15. Birthplace Lebanon, Kentucky

16 (a) Informant Mrs. Eliz. Handerty Phillips
(b) Address 700 W. Melrose Ave Roland Park

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10-3-45 (month) (day) (year)
(c) Cemetery or crematory Cremation
Location Balto., Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address [illegible]

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1945, at 3 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 30 1945 1 P M.
(b) Where did injury occur? Cylburn Ave, South of Belvedere Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Shot self

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 1st 1945

OCT 2 - 1945

G32867

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G32867

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Govans

(If outside city or town limits, write RURAL and give town)

(d) Street No. 814 Wampler Road.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-45

8. AGE: Years	Months	Days	If less than one day
		1/2	hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Harold E. Williams

13. Birthplace Texas

MOTHER — 14. Maiden Name Anna Mary Bruza.

15. Birthplace Md.

16 (a) Informant Parents.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 2-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Zion Lutheran

Location Sterling Run

18 (a) Funeral director John B. Donnelly

(b) Address Essex Md.

19 (a) OCT 2-1945 (b)

(Date received by registrar)

Entering for Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-29 1945, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-27 1945 to Sept-29 1945 and that I last saw him alive on Sept-29 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Rowena Sidney Hall Asst Res

Address Hopkins Hospital Date signed 9-29-45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

HEP G32868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32868 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 47 E. Heath Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard K King

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1880

8. AGE: Years	Months	Days	If less than one day
65	3	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name Thomas King
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia Wayson
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Harmony
Location Calvert Co Md

18 (a) Funeral director C. Howard Evans
(b) Address 140 S Charles St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1945, at 2:05A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26, 1945 to Oct. 1, 1945 and that I last saw h im alive on Oct. 1, 1945.

Immediate cause of death Coronary occlusion and cardiac failure — Duration
Due to arteriosclerosis
Due to
Other Conditions Ataxia due to syphilis?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jonathan Howard M. D.
Address 3 E H Date signed 10/2/46

VS 150

9 of a

G32869 ✓ G32869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 Grantley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 760 Grantley Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara B. Jory

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William B. Jory
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1866.

8. AGE: Years 79 | Months 1 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace York, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Phillippi
13. Birthplace France

MOTHER
14. Maiden Name Lena Dingler
15. Birthplace Unknown

16 (a) Informant Mrs. Grace Slaughter
(b) Address 3037 Arunah Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 8 4 1945 (month) (day) (year)
(c) Cemetery or crematory Western Bem
Location Baltimore Md

18 (a) Funeral director C. Howard Ellis
(b) Address 1[illegible]

(a) 8-1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945, at 6:30 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945, to Oct. 1, 1945 and that I last saw her alive on Oct. 1, 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lenger A Kemp
Address 3030 Edmondson Ave. Date signed 10/2/45

VS 150

X

632870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 632870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Cedar St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Todd

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-07-7727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Lucille Todd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/13/1910

8. AGE: Years	Months	Days	If less than one day
35	7	19	hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fulton Todd
13. Birthplace Md.

MOTHER
14. Maiden Name Williams
15. Birthplace Md.

16 (a) Informant Lucille Todd
(b) Address Cambridge Md

17 (a) Burial (b) Date thereof 10 7 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cambridge Cem.
Location Cambridge Md

18 (a) Funeral director Kenneth R. Thomas
(b) Address Cambridge, Md.

OCT 2 1945 (Date rec'd by registrar) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 1945 at 12 25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1945 to Oct-2, 1945 and that I last saw him alive on Oct 2 1945.

Immediate cause of death	Duration
Double Meningitis	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

per

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Dorcas Clark, M. D.
Address Greene & Redwood University Hosp. Date signed Oct 2 1945

632871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. 632871

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena S Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1892

8. AGE: Years	Months	Days	If less than one day
52	10 11	24	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name David Landsman
13. Birthplace Russia

MOTHER
14. Maiden Name Tishri ?
15. Birthplace Russia

16 (a) Informant Herman Frank
(b) Address 2903 Violet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 OCT 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 4.08

20. DATE OF DEATH October 1 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 1 1945, and that I last saw h[illegible] alive on Oct 1 1945.

Immediate cause of death	Duration
General Carcinomatosis	1 year
Due to Carcinoma descending colon	3 years
Due to	
Other Conditions Colostomy	1 year

(Include pregnancy within 3 months of death)

Date of operation June 1943 - Jan 1945

Major findings of operation: Carcinoma of Colon (descending colon)

of autopsy: Records at VM Hospital

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin E. Mayer

Address The Executor (17) Date signed 10/2/45

Edwin E. Mayer

G32872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 25

G32872 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name county)
(d) Street No. 1113 Newcomb Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella M. Tyndall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Jno I Tyndall

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) May 13 1915

8. AGE: Years 30 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace North Wilkesboro N.C. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Ambrose Whittington
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Jno Tyndall
(b) Address 1113 Newcomb Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-1945 (month) (day) (year)

(c) Cemetery or crematory
Location Wilkes County - N.C.

18 (a) Funeral director John C. Miller, Inc.
(b) Address 2433 E. Oliver St.

19 OCT 3 - 1945 (Date rec'd by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1945 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1945 to 10/2 1945 and that I last saw her alive on 10/2 1945.

Immediate cause of death Toxemia — Duration

Due to Generalized Peritonitis

Due to Gonorrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/27/45

Major findings of operation: Salpingitis

of autopsy: SALPING. GITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Jno Tyndall M.D.
Address St Joseph Hospital 10/2 45

VS 150

G32873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107 ✓ G32873 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Druid Hill Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Morton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Isaiah Morton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1900

8. AGE: Years	Months	Days	If less than one day
45	6	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Ada Myers
(b) Address 34 N. Fremont Ave

17 (a) Burial (b) Date thereof 10 - 4 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Cem
Location md

18 (a) Funeral director George W. Nelson
(b) Address 1303 Presstman St

19 (a) Date received by local registrar OCT 3 - 1945 (b) Signature of local registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 1 - 1945 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 - 11 - 1945 to 10 - 1 - 1945 and that I last saw him alive on 10 - 1 - 1945.

Immediate cause of death	Duration
Bronchopneumonia	Two days
Due to Hypostasis	
Due to	
Other Conditions Infected Foot	10 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 10-6-45

VS 150

632874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 632874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 N. Washington st
(c) Hospital or institution: &

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca E. Frey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Walter T. Frey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1st 1869

8. AGE: Years	Months	Days	If less than one day
75	11	0	hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mason E. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Beard
15. Birthplace Md.

16 (a) Informant Mrs. Ruth Frey
(b) Address 2711 Hampden Ave

17 (a) Burial (b) Date thereof 10/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) ~~Date rec'd by registrar~~ OCT 2 - 1945 (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1st 1945, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1945, to Oct 1 1945, and that I last saw h[illegible] alive on Sept 30 1945.

Immediate cause of death	Duration
Carcinoma Uterus	1 1/2
Due to	
Due to	
Other Conditions Metastasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Exploratory operation by Dr. Marino
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucas Fisher M. D.
Address 820 N. Wash St. Date signed 10/2/45

VS 100

X

G32875 ✓ G32875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Clipsmont Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Harold L. Elliott

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) June 5th 1885

8. AGE: Years	Months	Days	If less than one day
60	3	27	hr. min.

9. Birthplace Whitestone Virginia (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business B & O.

FATHER
12. Name (Unknown) Elliott
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna B. Clemmitt
(b) Address 3904 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 (a) Date received by registrar OCT 5 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1945, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1945 to 10/3 1945, and that I last saw him alive on 10/1 1945.

Immediate cause of death Cardio-Resp. failure — Duration
Due to Lower Pneumonia
Due to Diabetes Mellitus
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. M. Scott M. D.
Address University Hosp. Date signed 10/3/45

10 F

G32876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G32876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3232 Old Fred Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3232 Old Fred. Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John. B Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-6004

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married.

6 (b) Name of husband or wife Lillian B Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1886

8. AGE: Years	Months	Days	If less than one day
59	3	26	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Fireman.
11. Industry or business Shipyard.

FATHER
12. Name John H Collins
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E Smith
15. Birthplace Maryland.

16 (a) Informant Lillian B Collins
(b) Address 3232 Old Fred Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Fred Rd Balto City

18 (a) Funeral director Edgar S MacNabb.
(b) Address Catonsville Md.

19 (a) 10 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Dec 28 1945; and that I last saw h[illegible] alive on Dec 27 1945.

	Duration
Immediate cause of death: General Carcinomatosis	2 Mons.
Due to: Carcinoma of Liver	2½ Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 3932 Linden Ave Date signed

G32877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51D

✓ G32877 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Albemarle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Albemarle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Schmidt

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-22-3588

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15-1873

8. AGE: Years 71 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name John. Schmidt
13. Birthplace Germany

MOTHER 14. Maiden Name Mary R.
15. Birthplace Germany

16 (a) Informant Mary Schmidt
(b) Address 504 Albemarle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-45 (month) (day) (year)

(c) Cemetery or crematory Mount Olivet
Location Old Frederick Rd

18 (a) Funeral director John. A. Mahan
(b) Address 3005 E. Baltimore St.

19 (a) OCT 3 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1- 1945 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1945 to Oct. 1, 1945, and that I last saw him alive on Sept. 20, 1945.

Immediate cause of death	Duration
Carcinoma (Prostate Gland and Bladder)	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation about July 19, 1945

Major findings of operation: Carcinoma - bladder and Prostate.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cummings M. D.

Address 514 Drury Lane Date signed 10/1/45

VS 150

G32878 Simes ✓ G32878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 N. Castle st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Burley Simes Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col.	M.

6 (b) Name of husband or wife Minnie Simes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1911

8. AGE: Years	Months	Days	If less than one day
34	8	16	hr. min.

9. Birthplace Winnsboro, S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Burley Simes
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Brown
15. Birthplace S. C.

16 (a) Informant Minnie Simes
(b) Address 3 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/45 (month) (day) (year)

(c) Cemetery or crematory
Location Winnsboro, S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bland & Cayane

19 (a) Huntington Williams Wash
(Date received by registrar) Registrar

OCT 3 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-45 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/45 to 10-1-45
and that I last saw him alive on 10-1-1945.

Immediate cause of death Bronchial Pneumonia — Duration 8 days
Due to Empyema
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Blake M. D.
Address 1327 N. Central Ave Date signed 10/2/45

VS 150

GG32879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registration No. 632879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Bolton St
(c) Hospital or institution:

13-V

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Reinig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John C Reinig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1 1865

8. AGE: Years	Months	Days	If less than one day
80	1	2	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Groves
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Cain
15. Birthplace Pa

16 (a) Informant Richard E Platt
(b) Address 3600 N Belvedere Ave

17 (a) Burial (b) Date thereof Oct 4th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 OCT 3 - 1945 (Huntington Williams, MD) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1945 to 10/1 1945 and that I last saw h.er alive on 9/11 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis	years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Funk, M.D.
Address 724 W. North Ave Date signed 10/2/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G32880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Hilliard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Rose Hilliard
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct 12 1876

8. AGE: Years	Months	Days	If less than one day
68 69	11	18 19	hr. min.

9. Birthplace Newfoundland
(Town, county, and state)

10. Usual Occupation Insurance Agt

11. Industry or business

FATHER
12. Name Joe Hilliard
13. Birthplace Newfoundland

MOTHER
14. Maiden Name Dont Know
15. Birthplace Newfoundland

16 (a) Informant Rose Hilliard
(b) Address 2015 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 208 Orleans St

19 (a) Oct 3 1945 (Date received by registrar) (b) Huntington Wills (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8th 1945 to Sept 30th 1945 and that I last saw h[e] alive on Sept 30th 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to Atherosclerosis arteriosclerosis — Duration ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M J Faulkner M. D.
Address 100 Winthrop Date signed 10/2/45

X

G32881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G32881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct ... especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2735 North Charles Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Dell) Katherine Barni

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur Barni
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) June 3, 1904

8. AGE: Years	Months	Days	If less than one day
41	3	29	....hr. ....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Henry Kratz
13. Birthplace Germany

MOTHER
14. Maiden Name Anne Sabloski
15. Birthplace Baltimore

16 (a) Informant Arthur Barni
(b) Address 2735 N. Charles St.

17 (a) Burial (b) Date thereof Oct-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Eutaw St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1945, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to illuminating gas
Due to
Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-2-45 at A.M.
(b) Where did injury occur? 2735 N. Charles St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Gas in bedroom - Kitchen Gas Range

23. Signature Howard J. Clemens M.D.
Medical Examiner.
Date signed 10/2/45

VS 151

G32882

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

9

Registered No. G32882

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 E. PRATT ST (If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME ESAU BRACEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN 30, 1944

8. AGE: Years	Months	Days	If less than one day
1	8	1	hr. min.

9. Birthplace CAMDEN, SOUTH CAROLINA (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name RICHARD BRACEY
13. Birthplace BISHVILLE, South Carolina

MOTHER
14. Maiden Name ROBY MAY BLYTHER
15. Birthplace CAMDEN, S.C.

16 (a) Informant RICHARD BRACEY
(b) Address 1608 EAST PRATT ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co. Md.

18 (a) Funeral director Robert F. Williams
(b) Address 15-15 McElderry St

19 (a) OCT 2 — 1945 (Date rec'd by registrar) (b) Huntington W. Williams, Registrar, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 1 1945 at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1945, to Oct 1 1945, and that I last saw him alive on Oct 1 1945.

Immediate cause of death	Duration
respiratory failure	—
Due to probable encephalitis	1 week
Due to whooping cough	4 weeks
Other Conditions pneumonia, atelectasis, septicemia, otitis, diarrhea, (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed Oct 1 '45

X

G32883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 08

G32883 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Reach St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Reach St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/1892

8. AGE: Years	Months	Days	If less than one day
53		1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Wilson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Susie Ferguson
15. Birthplace Balto Md

16 (a) Informant Addie Jennings
(b) Address 40 E Churchill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) OCT 3 - 1945 (Date received by registrar) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1945, at 8.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Oct 1 1945, and that I last saw him alive on Oct 1 1945.

Immediate cause of death Mitral Insufficiency (Heart)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 1131 Harlem Ave Date signed Oct 1 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 632884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Arlington ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
23			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Robert Hill
13. Birthplace Balto Md

MOTHER
14. Maiden Name Doreen Crowner
15. Birthplace Md

16 (a) Informant Doreen Hill
(b) Address 213 N Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4. 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Sarah A Brownson
(b) Address 1018 W Monty omery Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1945, at 1 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following;
(a) Date of injury Sept 30 1945 12 20 A.M.
(b) Where did injury occur? 213 N. Arlington Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot during altercation

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 30 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

Registered No. G32885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 Hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Wythe
(c) City or town Brocketts
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold L. Phipps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13. 1909

8. AGE: Years	Months	Days	If less than one day
36	7	13 17	hr. min.

9. Birthplace Brocketts Va. (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business

FATHER 12. Name F. M. Phipps

13. Birthplace Bridger Creek Va

MOTHER 14. Maiden Name Flora Wampler

15. Birthplace Brocketts Va.

16 (a) Informant James M. Phipps

(b) Address 4809 Olney Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/1945 (month) (day) (year)

(c) Cemetery or crematory Kings Grove

Location Brocketts Va

18 (a) Funeral director Howard A. Gill

(b) Address 1911 W. Pennsa ave Towson

19 (a) OCT 5 1945 (Date rec'd by registrar) (b) Huntington for Gill Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1945 at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16-5

(a) Date of injury 9-30- at 10.30 P.M.

(b) Where did injury occur? Edmondson & Whaley Avenues

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Pedestrian struck by streetcar

23. Signature Howard J. Huntington M.D. Medical Examiner.

Date signed 10-1-45

G32886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G32886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1931

8. AGE: Years	Months	Days	If less than one day
14	-	15	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Lewis Roberts
13. Birthplace Va

MOTHER
14. Maiden Name Mary Shepard
15. Birthplace Va

16 (a) Informant Mr. Lewis Roberts
(b) Address 711 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto Md.

18 (a) Funeral director Mrs. Emma A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 3 - 1945 (Date rec'd by Registrar) (b) Registered

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1945, at 9 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s.n. death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Gaston M.D.
Medical Examiner.

Date signed 10-1-45

632887 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 632887 / 1243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 E. Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hakis (Psychias)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1898

8. AGE: Years	Months	Days	If less than one day
47 or 48	5	23	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business Restaurant

FATHER
12. Name John Hakis (Psychias)
13. Birthplace Greece

MOTHER
14. Maiden Name Virginia Madamos
15. Birthplace Greece

16 (a) Informant John Sakaros
(b) Address 1818 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangelismos
Location Balto Md.

18 (a) Funeral director John Miller
(b) Address 2436 Jefferson St.

19 (a) OCT 3 - 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1945, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchio pneumonia, fatty degeneration of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Fraham M.D.
Medical Examiner.
Date signed 10-1-45

632838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 632838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARCODE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
Church Home & Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss MARY C. MASON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1867

8. AGE: Years	Months	Days	If less than one day
77	9 10	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John T Mason
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Barnes
15. Birthplace Maryland

16 (a) Informant Mrs Graham
(b) Address 3004 Fremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 (month) (day) 45 (year)
(c) Cemetery or crematory Union Cem
Location Leesburg, Va.

18 (a) Funeral director D. E. Covington
(b) Address 2140 25 St Balto, Md.

19 (a) OCT 3 - 1945 (Date rec'd by registrar) Washington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945 at 6:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1945 to 10/2 1945 and that I last saw h[illegible] alive on 10/1 1945

Immediate cause of death	Duration
Pulmonary Edema	36 hrs
Due to Heart Failure	3-4 yrs.
Due to Hypertensive Cardiovascular Disease	10 yrs
Other Conditions Obesity	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest M. Laumann M. D.
Address Church Home & Hospital Date signed 10/4/45

VS 150

G32889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G32889 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 West Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Becker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband August P. Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1861

8. AGE: Years	Months	Days	If less than one day: hr.	min.
84	2	24		

9. Birthplace Ellicott City, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name Edward Norris
13. Birthplace England

MOTHER
14. Maiden Name Emaline Appleby
15. Birthplace Md.

16 (a) Informant Julia Habighurst
(b) Address 2721 W. Mosher St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/5/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St Paul st.

19 (a) OCT 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Oct 2 1945, and that I last saw h e alive on Oct 2 1945

Duration

Immediate cause of death Uremia
1935. ~~Pneumonia~~ Fat Embolism
explanation
Due to Fract of femur.
Pneumonia
Due to Malnutrition
hypostasis
Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Malnutrition, coronary sclerosis pulm. congestion

PHYSICIAN
Underline the cause to which death should be charged under

22. If death was due to external causes, fill in the following: 16/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence September 28 1945 M
(c) Where did injury occur 2721 W. Mosher Street
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Slipped and fell to floor

23. Signature Osmund Weiness M. D.
Address Univ. Hosp. Date signed 10-2-45

X Thomas J. Mullen, M. D. X

D

G32890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G32890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3017 Independence st

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3017 Independence St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Hoxter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Blanche C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24th 1879

8. AGE: Years	Months	Days	If less than one day
66	3	7	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Insurance Collector

11. Industry or ~~business~~ Home Fire Ins. Co.

FATHER
12. Name George T. Hoxter
13. Birthplace Md

MOTHER
14. Maiden Name Sarah McComas
15. Birthplace Md

16 (a) Informant Blanche C. Hoxter
(b) Address 3017 Independence St

17 (a) Burial (b) Date thereof 10/4/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul st

19 (a) (Date received by registrar) (b) Registrar

OCT 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1st 1945 at 3:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1943, to 10-1 1945, and that I last saw him alive on Apr. 23, 1945.

Immediate cause of death	Duration
Angina Pectoris	Immediate
Due to Arteriosclerosis	about 3yrs
Due to -------	
Other Conditions Myocarditis	--------

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Howard L. Meeden, M.D.

Address 401 E. 25th. St. Date signed 10/2/45.

Howard L. Meeden, M.D.

M. D. H. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G32891

CERTIFICATE OF DEATH

93D

G32891

1. PLACE OF DEATH 1701 n. Ellamont ave 5/6

CITY OF BALTIMORE: (No. F St., Ward) 15

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Bertha Gordon Kagen

(a) Residence: No. 1701 ELLAMONT St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
female	w	Widow

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Kagen

6. DATE OF BIRTH (month, day, year) May 9, 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	91	4 5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation life

12. BIRTHPLACE (city or town) Russeina
(State or country) Lithuania, Europe

FATHER

13. NAME Jacob Gordon

14. BIRTHPLACE (city or town) Malat
(State or country) Lithuania, Europe

MOTHER

15. MAIDEN NAME ~~Bertha~~ Pauline Gordon

16. BIRTHPLACE (city or town) Malat
(State or country) Lithuania, Europe

17. INFORMANT Marie Kagan Rosenblatt
(Address) 3018 O'Donnell St.

18. BURIAL, CREMATION, OR REMOVAL
Place SOUTH HILL, YORK, Pa. Date 10/3 1945

19. UNDERTAKER Wilson & Cook Inc
(Address) 1544 Eutaw St

20. FILED 1945 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) October 3, 1945

22. I HEREBY CERTIFY, That I attended deceased from June 14, 1944 to Octob. 3, 1945

I last saw her alive on Octob. 2, 1945. Death is said to have occurred on the date stated above, at 7:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Chronic Myocarditis	Unknown

Other contributory causes of importance:

Senile Myocarditis Senilis	4
Decubitus	3 weeks

Name of operation none Date of

What test confirmed diagnosis? Clin. Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify

(Signed) L. A. Rosenblatt M. D.

(Address) 3018 O'Donnell St.

X

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 33892

33892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Madison & Lindis

(c) Hospital or institution: Md. Gen Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 217 E 25th (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Pearl L. Roskom

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1904

8. AGE: Years 41 Months 2 Days 27 If less than one day hr. min.

9. Birthplace Shamokin Pa (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mahmoud Kucuk

13. Birthplace Pa

MOTHER 14. Maiden Name Mahmoud

15. Birthplace

16 (a) Informant Henry W Roskom

(b) Address Chicago Ill

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/3/45 (month) (day) (year)

(c) Cemetery or crematory Lexington

Location Chicago Ill

18 (a) Funeral director Wilson Colonial

(b) Address 1219 E 63rd St

19 (a) OCT 2 1945 (Date rec'd by registrar) (b) Thurston Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to 1945 and that I last saw h.r alive on Oct 1 1945

	Duration
Immediate cause of death Cachexia	
due to Metastatic carcinoma of lungs	
Due to Carcinoma of left breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. M. Cancello M. D.

Address Md. Gen Hosp Date signed 10-1-45

VS 150

PING

G32893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G32893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chang Ping

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: Chinese

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace China (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name Chang Sing
13. Birthplace China

MOTHER
14. Maiden Name Lau She
15. Birthplace China

16 (a) Informant Mr. John J. Morrison (Cousin)
(b) Address 217 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Stewart & Hower Co.
(b) Address 108 N. North Ave.

19 OCT 3 - 1945 (b) Huntington W. Va. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945, at 5 25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 12-5

(a) Date of injury Oct. 1 at 1945 11 35 P.M.
(b) Where did injury occur? Pennsylvania R.R. Station
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Jumped from train to R.R. platform

23. Signature Robert L. Gutman M.D.
Medical Examiner.
Date signed Oct. 3 1945

G32894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 E. Hoffman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 E Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M Norwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian M. Norwood
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 6-3-1869

8. AGE: Years	Months	Days	If less than one day
76	3	28	hr. min.

9. Birthplace Upper Falls Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Government Service

FATHER
12. Name James L. Norwood
13. Birthplace Upper Falls Md

MOTHER
14. Maiden Name Harriett Norwood
15. Birthplace Balto Co.

16 (a) Informant Roland B Norwood
(b) Address 321 Dunbarton Road

17 (a) Buried (b) Date thereof 10-4-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Salem M.E.
Location Upper Falls Md.

18 (a) Funeral director John C Miller Inc
(b) Address 2432 E Oliver St

19 (a) (Date rec'd by registrar) OCT 3 1945 (b) Huntington Hollins Registrar MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 1 1945 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2, 1945. to Oct. 1, 1945. and that I last saw h im alive on Sept. 30, 1945.

Immediate cause of death Hemorrhagic infarction and thrombosis of right lung. — Duration: 3 weeks
Due to Arteriosclerosis — 1 yr.
Due to
Other Conditions Chronic Myocarditis 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Longwell
Address 1613 E. North Av. Date signed 10-2-45

VS 150

111a

G32895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

G32895 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Keswick + 40th Sts.
(c) Hospital or institution: Md Car Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Smithwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Diehlmann

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-0666

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife E. Irene Diehlman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	14	hr. min.

9. Birthplace Catonsville, Md.
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Frederick Diehlmon
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Beckmon
15. Birthplace Germany

16 (a) Informant Mrs E. Irene Diehlmon
(b) Address 110 Smithwood Ave. Caton

17 (a) Burial (b) Date thereof Oct. 4 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md

19 (a) OCT 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1945, at 3.25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Auricular Fibrillation

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dougl B. McKelvey Medical Examiner.
Date signed Oct. 2, 1945

VS 151

G32896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G32896

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Harlem ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA M. COWLEY

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband HERBERT S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 4, 1877

8. AGE: Years 68 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name (?) KOERNER
13. Birthplace Md.

MOTHER
14. Maiden Name ANNA M. HOFFMAN
15. Birthplace Md.

16 (a) Informant RUSSELL COWLEY
(b) Address 120 CLARENDON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK INC
(b) Address 1217 ST. PAUL ST.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1945, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945 Oct. 3 1945, and that I last saw her alive on Oct. 2 1945.

Immediate cause of death	Duration
Pneumonia Lobar RUL	14 hrs
Due to	
Due to	
Other Conditions Cardio Vascular Renal DIS 2 yrs (Include pregnancy within 3 months of death)	1 yr

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. P. Johnson M.D.
Address 403 Medical Arts Date signed 10-3-45

VS 150

G32897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 Aisquith ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Aisquith ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Waltman

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1891

8. AGE: Years	Months	Days	If less than one day
54	6	-	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Elias Waltmon
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Julia Miller
15. Birthplace Littlestown Pa

16 (a) Informant Florence Mineck
(b) Address 1501 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fulhorn & Lyon Inc
(b) Address 1217 E Lond St.

19 (a) (Date rec'd by registrar) (b) Harrington Wilson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945, at 4:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Vegetative Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct 2 1945

VS 151

G32898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G32898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Fayette St
(c) Hospital or institution: Bon Secours Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Prestman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen G. Wareheim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herbert Wareheim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19 1899

8. AGE: Years 47 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Ernest Beck

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Maud Stubbs

15. Birthplace Virginia

16 (a) Informant S. Herbert Wareheim

(b) Address 2806 Prestman St.

17 (a) Burial (b) Date thereof Oct 4 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore Md.

18 (a) Funeral director Annie E. Syfer

(b) Address 1600 W. Lorraine.

19 (a) 10-3-1945 (b) Herbert Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/45 1945 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5/45 1945 to 9/30/45 1945 and that I last saw her alive on 9/30/45 1945.

Immediate cause of death Malnutrition - Cachexia

Due to C.A. Desc. Colon

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/16/45

Major findings of operation: Resect of Colon

of autopsy: none

Duration
4 hrs
25 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Norton M.D.

Address Roy Barnes Bldg. Date signed 9/30/45

G32899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G32899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 N. College Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	widow

6 (b) Name of husband or wife John Thompson (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1883

8. AGE: Years	Months	Days	If less than one day
62	3	23	hr. min.

9. Birthplace Chestertown, Kent, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. James Lively.
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Annie Henson.
15. Birthplace Chestertown, Md.

16 (a) Informant Nettie Robinson (sister)
(b) Address 519 N. Sticker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-'45. (month) (day) (year)

(c) Cemetery or crematory
Location Chestertown, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1945, at 10:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1945, to Oct. 1, 1945, and that I last saw her alive on Oct. 1, 1945.

Immediate cause of death	Duration
Pulmonary Embolism or Coronary Embolism	
Due to Hypertensive Cardiovascular Disease	
Due to Diabetes Mellitus and other unknown factors	
Other Conditions Prim. Optic Atrophy (Include pregnancy within 3 months of death)	

Date of operation Sept. 25, 1945
Major findings of operation: Embolism Coronary, left heart
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address University Hosp. Date signed 10/1/45

VS 180

GAFFey

G32900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G32900 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2906 Louise Ave

(c) Hospital or institution: # # #

(d) Length of stay in hospital or inst. (yrs., mos., or days) #

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2906 Louise Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Annie Caffey

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John T. Caffey

6 (c) If alive, give age # years

7. Birth date of deceased (mo., day, yr.) Oct 23-1863

8. AGE: Years 81 | Months 11 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Wilmington, Del. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER

12. Name Thomas Carroll

13. Birthplace Ireland

MOTHER

14. Maiden Name Alice Colbert

15. Birthplace Ireland

16 (a) Informant William. J. Caffey

(b) Address 2906 Louise Ave.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Oct 5. 45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Evans & Son

(b) Address 118 W. Mt Royal Ave

19 (a) OCT 3 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 2 1945, and that I last saw h alive on Oct 2 1945.

Immediate cause of death: Generalized Arteriosclerosis — Duration: 10 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Salem M.D.

Address 6217 Harford Rd Date signed 10/4/45

M.D.

VS 150

X

G32901 BALTIMORE CITY HEALTH DEPARTMENT X G32901
Registered No.

CERTIFICATE OF DEATH 1119a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C (b) County
(c) City or town Charleston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Murray Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H. Ellerbe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-44

8. AGE: Years	Months	Days	If less than one day
	10 9	2	hr. min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William H. Ellerbe
13. Birthplace S.C.

MOTHER
14. Maiden Name Lois Middleton
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Magnolia Cemy.
Location Charleston S.C.

18 (a) Funeral director John D. Mitchell Funl Dir
(b) Address 1900 Eutaw Place

19 (a) 10-4-1945 (b)
(Date rec'd by registrar) Herington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1945, at 11 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 19 45 to Oct 3 1945, and that I last saw h alive on Oct 3 19 45

Immediate cause of death	Duration
Cystic Fibrosis of Pancreas	9 mos
Due to Diarrhea	3 days
Due to (Pneumonia)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Romona Sidbury Hall Asst Cor M. D.
Address Hopkins Hospital Baltimore Md Date signed 10-3-45

VS 150

Main G32902

CMK-96393

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 B

Registered No. G32902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 Mins
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 W. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Jesse Hite

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Hite
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1908

8. AGE: Years	Months	Days	If less than one day
36	10	6	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse Hite
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Snyder
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1945, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Oct. 1 1945, and that I last saw h 1m alive on Oct. 1 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Tuberculosis Enteritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert D. Copeland Jr. M.D.
Address Balto. City Hospitals Date signed 10/4/45

Certificate to be approved by Assistant Registrar

VS 150

For P.N.B. Re-Hollis, Jr. - Howard J. Andersen, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 Year 632903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 632903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5207 Craig Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5207 Craig Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William McKee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Minnie Kelley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1862

8. AGE: Years	Months	Days	If less than one day
83	4	28	hr. min.

9. Birthplace Ohio.
(Town, county and state)
10. Usual Occupation Retired Blacksmith
11. Industry or business B+O. R.R.

FATHER
12. Name William McKee
13. Birthplace Penna

MOTHER
14. Maiden Name Mary May
15. Birthplace —

16 (a) Informant Mrs Minnie McKee
(b) Address 5207 Craig Ave.

17 (a) Burial (b) Date thereof 10/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Wiltze
(b) Address 41016 Edmondson Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1943 to Oct. 1, 1945 and that I last saw him alive on Oct. 1, 1945.

Immediate cause of death Chronic myocardial insufficiency — Duration 1 yr.

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Greytone M.D.
Address 3963 Greenmount Ave Date signed 10/2/45.

VS 150

G32904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32904 / 48 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 W. Fayette St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Lithuania

3 (a) FULL NAME Eva Shilaika

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-3908

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
73?			hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business ?

FATHER
12. Name Ignatius Kalinauskas
13. Birthplace Lithuania

MOTHER
14. Maiden Name Marion VeVeesite
15. Birthplace Lithuania

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4420 Belair Road

18 (a) Funeral director John J. Grabiauskas Jr.
(b) Address 423 S. Paca St.

19 (a) OCT 3 - 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1945 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1945 to Oct 1 1945 and that I last saw her alive on Oct 1 1945

	Duration
Immediate cause of death Circulatory Collapse	16 hrs
Due to Carcinomatosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 25, 1945
Major findings of operation: Carcinoma tests from uterus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent de P. Fitzpatrick M.D.
Address Mercy Hospital Date signed Oct 4 1945

VS 150

G32905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

G32905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD. STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 MARYLAND AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MISS FLORENCE AUGUSTA STERLING

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	SINGLE

6 (b) Name of husband or wife NONE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) OCT. 31, 1876

8. AGE: Years	Months	Days	If less than one day
68	11	1	— hr. — min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation RETIRED SCHOOL TEACHER
11. Industry or business —

FATHER
12. Name JAMES RANDOLPH STERLING
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name CAROLINE E. COPES
15. Birthplace VIRGINIA

16 (a) Informant FROM PREVIOUS ADMISSION
(b) Address —

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/5/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) OCT 4 - 1945 (b) Huntington Willi... (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 2, 1945; at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945, to Oct. 2, 1945, and that I last saw h.. alive on Oct. 2, 1945.

Immediate cause of death	Duration
cardio-respiratory failure	
Due to gangrene ileum	
Due to volvulus	
Other Conditions, Chronic congestive cardiac failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: gangrene ileum due to volvulus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford W. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 10-2-45

VS 150

G32906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F Registered No. G32906

HB 96164

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The ... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Hargrove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brown Simon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.? 1884

8. AGE: Years	Months	Days	If less than one day
60?	11 ?	?	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Anderson
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. A. W.

18 (a) Funeral director Rayner Sanders
(b) Address 1413 E. Preston St.

19 (a) Date rec'd by Registrar (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 19 45 at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 19 45 to Oct. 1, 1945, and that I last saw him alive on Oct. 1 19 45

Immediate cause of death: Carcinoma of liver — metastasis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto City Hosp Date signed 10-2-45

VS 150

G32907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 Q

Registered No. G32907

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 441 E. 22nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 441 E. 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. WRIGHT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife James G. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1874

8. AGE: Years	Months	Days	If less than one day
70	11	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Phillip Hess
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Rooney
15. Birthplace Ireland

16 (a) Informant Mrs. Mary A. Hohrein
(b) Address 520 Beaumont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1945, at 2:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Oct 1945 and that I last saw her alive on Oct 2 1945.

Immediate cause of death Carcinoma of right Kidney — Duration 6 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. V. Rangle M.D.
Address 642 Wash Blvd Date signed 10-3-45.

Raymond V. Rangle

632908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No. 632908

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4309 Wentworth Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4309 Wentworth Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK WILLIAM KOCH, JR.

3 (b) If veteran, name war World War-1-

3 (c) Social Security Account No. 139-05-0153

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Caroline Koch
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1893

8. AGE: Years	Months	Days	If less than one day
52	10	9	hr. min.

9. Birthplace Jersey City, N. J. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Francis H. Leggett

FATHER
12. Name Frederick Wm. Koch, Sr.
13. Birthplace St. Louis, Mo

MOTHER
14. Maiden Name Lydia A. Ray
15. Birthplace Syrocuse, N, Y.

16 (a) Informant Mrs. Caroline Koch
(b) Address 4309 Wentworth Rd.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 10/4/45 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cem.
Location Brooklyn, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Death rec'd by registrar) **(b)** Huntington Willis Registrar

OCT 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1945, at 7:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944 to Oct 2 1945 and that I last saw him alive on Oct 2 1945.

Immediate cause of death Carcinoma of descending colon — **Duration**

Due to

Due to

Other Conditions Intestinal obstruction — 2 days

(Include pregnancy within 3 months of death)

Date of operation July 10- 1945

Major findings of operation: Carcinoma

a 2d operation performed May 26 1945

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.

Address 2306 Eutaw Pl Date signed 10-3-45

Henrietta Krickhan Geyer

G32909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G32909

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Ramsay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 86 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Ramsay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henrietta Krickhan Geyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wht | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-1859

8. AGE: Years 86 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Buschman

13. Birthplace Germany

MOTHER 14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant R. Krickhan

(b) Address 934 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Frederick Ave

18 (a) Funeral director Geo. H. Leimbach

(b) Address 528 N Fyndhurst St.

19 (a) OCT 4 - 1945 (Date rec'd by local registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Oct 3 1945 and that I last saw h alive on Sept 30 1945

Immediate cause of death Cardiac Hemorrhage — Duration 3 hrs

Due to Senile Degeneration — 3 mos

Due to Bronchitis — chr

Other Conditions (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Harlan M. D.

Address 6 Randall Date signed 10/4/45

G32910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G32910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 1402 Madison Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country —

3 (a) FULL NAME Lavinia Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4, 1870

8. AGE: Years 75 | Months 8 | Days 28 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name John W Watkins

13. Birthplace Md

MOTHER 14. Maiden Name Mary Simpson

15. Birthplace Md

16 (a) Informant Mr. John W. Watkins

(b) Address 2346 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)

(c) Cemetery or crematory Arlington Mem. Park

Location Balto. Co., Md.

18 (a) Funeral director Mrs. F. Tennace T. Hennelly

(b) Address 578 W. Biddle St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Oct 2, 1945 and that I last saw her alive on Oct. 2, 1945.

	Duration
Immediate cause of death bronchopneumonia	24 hrs.
Due to	
Due to intestinal obstruction	17 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James D. Carr M. D.

Address 515 Morley St Date signed 10. 3. 45.

G32911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 Registered No. G32911

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2463 Shirley ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2463 Shirley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Israel Dubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Freyda
15. Birthplace Russia

16 (a) Informant Sophie Dubin
(b) Address 2463 Shirley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Saratoga St

OCT 4 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1945, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Oct 4 1945, and that I last saw h alive on 10/4/45

Immediate cause of death: Cerebral arteriosclerosis
Due to: subarachnoid hemorrhage
Due to: left hemiplegia
Other Conditions

Duration
5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 2464 Rembert Rd Date signed 10/4/45

G32912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G32912 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Brookfield Ave
(c) Hospital or institution: 131
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sara Haas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Leopold Michael
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant Leo L. Haas
(b) Address 2207 Brookfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis & Son
(b) Address 1619 E Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3rd 1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to Oct 3rd 1945.
and that I last saw her alive on Oct. 2nd 1945.

Immediate cause of death: Marasmus — Duration

Due to: general arterio-sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold H. Bix M. D.
Address 2516 Linden Ave Date signed 10-3-45

X

G32913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

Registered No. G32913

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 Dover St
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Veronica Richards

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-3-45

8. AGE: Years	Months	Days	If less than one day
●	6	29	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Columbus Richards
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lillian ?
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 632 Dover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-45 (month) (day) (year)
(c) Cemetery or crematory Magothy
Location Magothy md. a a Co.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penn. Ave

19 (a) OCT 4 - 1945 (Date rec'd by registrar) (b) Huntington Hill Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1945, to 10-2 1945, and that I last saw her alive on 10-2 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chakrajah Spraguins
Address Sydenham Hosp. Date signed 10-2-45

G32914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83

Registered No. G32914

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Woodland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Woodland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE R. SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	216-07-3223 B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie T. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Mrs. Minnie T. Smith
(b) Address 3503 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 - 1945 (Date rec'd by registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1945, at 10.05 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 2 1945 to OCT 3 1945 and that I last saw him alive on OCT 3 1945

Immediate cause of death Cerebral Hemorrhage — Duration 10/2/45
Due to
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Burbert M. D.
Address 805 Park Heights Ave Date signed 10/4/45

Hittel

632915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 632915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 S. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Hittel

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anne Ethel Hittel
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1894

8. AGE: Years 50 | Months 9 | Days 6 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Machinist
11. Industry or business: B & O. R.R.

FATHER
12. Name: Martin C. Hittel
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Mary Miller
15. Birthplace: Unknown

16 (a) Informant: Anne Ethel Hittel
(b) Address: 616 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwab
(b) Address: 2101 Frederick Ave.

19 OCT 4 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Oct 3 1945, and that I last saw him alive on Oct 3 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 10 days
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Albert Kornmesser, M.D.
Address: 1934 Wilkens Av Date signed 10/4/45

632916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 632916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilkins + Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5723 First Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Clark

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Clark
13. Birthplace Michigan

MOTHER
14. Maiden Name Dorothy
15. Birthplace Canal Zone

16 (a) Informant Father
(b) Address 5723 First Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Hunting for Williams 10/4/45 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1945 at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1945 to 10/4 1945 and that I last saw h[illegible] alive on 10/4 1945.

Immediate cause of death Cardiac failure — Duration

Due to Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address St Agnes Hosp Date signed 10/4/45

G32917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32917
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Tivoly Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Tivoly Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta E. Rehbach

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank Rehbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1860

8. AGE: Years 85 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation Home - Wife

11. Industry or business

FATHER
12. Name Henry Lucke
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Zerdinger
15. Birthplace Germany

16 (a) Informant Ottilie E. Cosden
(b) Address 2707 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Wm. John H. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) (Date rec'd by registrar) 1945 (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1939 to Oct 3rd 1945 and that I last saw her alive on Oct 2 1945.

Immediate cause of death: Cardiac Decomp — Duration: 2

Due to: Arteriosclerotic CVD & Hypertension — Duration: 7

Due to: — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Lumanick M. D.
Address 71 Dallas Date signed 10-3-45

X

G32918 — BALTIMORE CITY HEALTH DEPARTMENT — G32918 A — Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo. ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 N. Bond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
61 ?			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Service Work
11. Industry or business —

FATHER
12. Name Samuel Adkins
13. Birthplace North Carolina

MOTHER
14. Maiden Name Annie ?
15. Birthplace North Carolina

16 (a) Informant Record
(b) Address Mercy Hospl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brandt Lane

19 (a) (b) Registrar

(Date rec'd by registrar) 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1945, at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1945 to 9/30 1945, and that I last saw h[illegible] alive on 9/29 1945

Immediate cause of death Pneumonia — Duration 5 days

Due to Unable to Obtain Ambulatory Lack of Resistance

Due to

Other Conditions Hypertensive Cardio Vascular Failure & Decompensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Abell, Jr. M. D.
Address Date signed

VS 150

109

G32919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Darling DOTTY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace St. Mary's Co. Md. (town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Bob. Hill
13. Birthplace Md

MOTHER
14. Maiden Name Liza Hill
15. Birthplace md.

16 (a) Informant Mary Douglas
(b) Address 816 W. Dallas st -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/37 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Eden & Eyre

19 (a) 1937 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1937, at 4:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Kubinski M.D. Medical Examiner.
Date signed 10/1/37

VS 151

G32920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G32920 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 529 Bloom St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Ballotely
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Bloom St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Merryweill T Holland

3 (b) If veteran, name war: no
3 (c) Social Security Account No: none

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Fetik Holland
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 26 1867

8. AGE: Years 78 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Richard Addison
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden Name Mary Kelley
15. Birthplace Montgomery Co Md

16 (a) Informant C. B. Holland (son)
(b) Address 529 Bloom St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 5 45
(month) (day) (year)

(c) Cemetery or crematory Pinkneys
Location near Ellicott City

18 (a) Funeral director Wm J. Chatsmaby Jr
(b) Address 6009 Princeton ave. Balto. Md.

19 (a) 1945 (Date received by registrar) (b) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1945, at 8.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Oct 2 1945, and that I last saw h[illegible] alive on July 1945.

Immediate cause of death: Coronary Occlusion — Duration: 1/2 hr

Due to: a)

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Hughes
Address 8 W N. Fremont Ave Date signed 10/3/45
M D

VS 150

G32921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

Registered No. G32921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Creamer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Herold.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 28-1913

8. AGE: Years	Months	Days	If less than one day
32	2	3	hr. min.

9. Birthplace Wilmington Del
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Francis Stearett
13. Birthplace Wilmington Del

MOTHER
14. Maiden Name Julia Simpson
15. Birthplace Wilmington Del.

16 (a) Informant Jno. J. Doherty
(b) Address Wilmington Del.

17 (a) Burial (b) Date thereof Oct. 6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington Del.

18 (a) Funeral director John J. Moran
(b) Address 360 E. Balto St.

19 (a) OCT 4 - 1945 Wilmington Del
Date rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1945, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3- at P. M.
(b) Where did injury occur? 1023 N. Charles St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas range - unlit jets

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-4-45

VS 151

G32922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32922 / 83a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Overlea
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7007 Linden Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Louise E. Adams Louise Adams

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Thomas D. Adams
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1874

8. AGE: Years	Months	Days	If less than one day
70	10	2	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business .....

FATHER
12. Name Leipold Ramsel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schneider
15. Birthplace Germany

16 (a) Informant Mrs. Esther L. Meisz
(b) Address 6112 Fair Oaks Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road.

19 (a) 10-4-1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1945 at 6:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 10/3/45

VS 151

G32923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G32923

Registered No. _____

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD. STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) NOT KNOWN

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 N. CALVERT STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MRS. DONA ZILE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife WILLIAM D. ZILE
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 8-11-1873

8. AGE: Years	Months	Days	If less than one day
64	1	20	— hr. — min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name WILLIAM BARNES
13. Birthplace MARYLAND

MOTHER
14. Maiden Name DONA ELIZABETH INGLES
15. Birthplace MARYLAND

16 (a) Informant DECEASED - PRIOR TO DEATH
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)
(c) Cemetery ~~crematory~~ EDENSON
Location Winfield Carroll Co. Md

18 (a) Funeral director E. M. Wall
(b) Address Winfield, Md

19 (a) 10-1945 (Date rec'd by registrar) (b) _____ Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 2 1945 at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1945 to 10/2 1945 and that I last saw her alive on 10/2 1945

Immediate cause of death PERIPHERAL VASCULAR COLLAPSE

Due to CARCINOMA OF RECTO-SIGMOID WITH PROBABLE METASTASES

~~Due to~~ _____

Other Conditions _____

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: _____

of autopsy: _____

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) — (County) — (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm. D. Zile III

Address Union Mem. Hosp. Date signed 10/2/45 M.D.

X

G32924 BALTIMORE CITY HEALTH DEPARTMENT G32924
Registered No.

CERTIFICATE OF DEATH ✓178X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roosevelt White

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Halifax Co., Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Western Electric Co

FATHER
12. Name Edgar Barksdale
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy White
15. Birthplace Virginia

16 (a) Informant Herman Daniel Barksdale
(b) Address 1210 E. Preston St

17 (a) Burial (b) Date thereof 10/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph S. Locks & Co
(b) Address 1304 N. Central Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

10-4-1945 Vs 51 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1945, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Probably Carbon Monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-1- at 25/2 11:20 a. M.
(b) Where did injury occur? Western Elec. Co. - 1101 Bonaparte St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Cleaning empty wine tank.

23. Signature Howard S. Mesmer M.D.
Medical Examiner.
Date signed October 1, 1945.

X

G329,25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G329,25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution:
The Home for Incurables 13-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th. St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cora L. McCandlish

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Robert McCandlish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1858

8. AGE: Years	Months	Days	If less than one day
87	-	20 19	hr. min.

9. Birthplace Martinsburg W. Va
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Landstreet
13. Birthplace Balto - md -

MOTHER
14. Maiden Name Mary Swink
15. Birthplace Fairfax Va

16 (a) Informant Mrs. W. Carson
(b) Address 700 W. 40th St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director Charles R. Bast
(b) Address Hancock, Md.
19 (a) Date received (month) (day) (year) (b) Huntington Williams, M.D. Registrar
OCT 5 1945
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1940 to 10/4 1945, and that I last saw h[illegible] alive on 10/4 1945.

Immediate cause of death	Duration
Coronary Sclerosis	3 years
Due to Arteriosclerosis (Generalized)	10 years
Due to Diabetes Mellitus	15 years
Other Conditions Hypertrophic arthritis Hemiplegia (Right) - 6 years	20 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Hergenger M. D.
Address 214 Medical Arts Bldg Date signed 10/6/45

G329,26

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G329,26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20 1873

8. AGE: Years	Months	Days	If less than one day
72	1	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER 12. Name Owen Ward

13. Birthplace Md

MOTHER 14. Maiden Name Mary Spencer

15. Birthplace Md.

16 (a) Informant Miss. Esther Spicer

(b) Address 2004 Park Ave

17 (a) Burial (b) Date thereof 10/5/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Park

Location Taylor Ave

18 (a) Funeral director Howard N. Bligh Jr

(b) Address 4914 Belair Road

19 (a) (b) Arthur Williams, Registrar
(Date rec'd by registrar)

OCT 5 - 1945

VS Rev

8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1945, at 10:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1944, to Oct 3 1945, and that I last saw him alive on Sept 28 1945.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. N. Patterman M. D.

Address 2324 Reisterstown Rd Date signed 10/4/45

X

G32927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

G32927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Pine Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Washington Ross

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 217-01-8948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife: Elenora
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 6 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
54	7	1		

9. Birthplace: Charlottesville, Va. (town, county, and state)
10. Usual Occupation: Laborer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Elenora Mary Ross - wife
(b) Address: 515 Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location

18 (a) Funeral director: Adolphus Halstead
(b) Address: 918 Druid Hill Ave

19 (a) (Date rec'd by Registrar) OCT 5 - 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1945, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Broncho-pneumonia
Due to
Other Conditions Syphilis, Leg ulcers
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D. Medical Examiner
Date signed 10-3-45

107

632928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 632928

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. Read St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 W. Read St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1884

8. AGE: Years	Months	Days	If less than one day
60	9	2	hr. min.

9. Birthplace Lutherville, Md. (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Reproduction Plant

FATHER
12. Name James H. Scott, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine
15. Birthplace ?

16 (a) Informant Ellen N. Scott - wife
(b) Address 130 W. Reed St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)
(c) Cemetery or crematory Lincoln Cemetery
Location Washington, D. C.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 5 — 1945 (Date received by registrar) Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2, 1945, at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1945 to 10-2 1945 and that I last saw h-- alive on 10/2 1945

Immediate cause of death	Duration
Cardio - Renal	
Due to	
Due to	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Fletcher
Address 1725 Park Ave. Date signed 10/4/45

X

HEP #96149 63292 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. 63292 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Weeks

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-6968

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	10	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franklin Pierce Weeks
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Cramblitt
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 6-1945 (month) (day) (year)

(c) Cemetery or crematory
Location Manassas Virginia

18 (a) Funeral director Pratt C. B. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by reg'r of d.) **(b)** Huntington Williams, M.D. Registrar

OCT 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th, 1945, at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18, 1945, to Oct. 4, 1945, and that I last saw her alive on Oct. 4, 1945.

Immediate cause of death
Debility due to
Due to generalized Carcinomatosis primary uterus
Due to + intestinal obstruction obstruction relieved operatively
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-29-45
Major findings of operations intestinal obstruction + Ca of uterus.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Adrian Pabenibet M. D.
Address Baltimore C. H. Date signed 10-4-45

X

632930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

632930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene, Lombard St
(c) Hospital or institution:
University Hosp Baltimore Md 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 N. Abington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Medicus / Ann L Medicus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/45

8. AGE: Years | Months | Days 13 | If less than one day hr. min. 14

9. Birthplace Franklin Square hosp. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Leo L. Medicus
13. Birthplace Baltimore md

MOTHER
14. Maiden Name Frances L. Lestrey
15. Birthplace Baltimore md

16 (a) Informant Leo. L. Medicus
(b) Address 32 N. Abington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director W. G. Wappert & Son
(b) Address 800 N. Gilmore St

19 OCT 5 - 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2nd 1945, to Oct 4 1945, and that I last saw her alive on Oct 4th 1945.

Immediate cause of death Acidosis & dehydration — **Duration**

Due to epidemic diarrhea of newborn

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. McCulloch Jr M.D.

Address University Hosp Date signed 10-4-45

G32931 Speier ✓ G32931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4101 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Forest Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paula Speier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Max Speier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman -
13. Birthplace Germany

MOTHER
14. Maiden Name Hedwigh -
15. Birthplace Germany

16 (a) Informant Max Speier
(b) Address 4101 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos. Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) Huntington Williams M.D. Registrar
Registered OCT 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3-45 19 , at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1945 to 10/3 1945, and that I last saw he alive on 10/2 1945.

Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 1206 E. Lafayette Ave Date signed 10/4/45

VS 150

X

632932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 632932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 John St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Rose Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23rd 1874

8. AGE: Years 71 | Months 4 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Patrick Collins
13. Birthplace Ireland

MOTHER
14. Maiden Name Jane O'Connor
15. Birthplace Ireland

16 (a) Informant Nellie Collins
(b) Address 1624 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) 5 – 1945 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1945 to Oct 3 1945, and that I last saw h[er] alive on Oct 3 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. J. Kirby, M. D.
Address 1106 E. Northern Date signed Oct 4 45

VS 150

632933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 632933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1438 Mountmor Ct.
(c) Hospital or institution:
15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1438 Mountmor Ct. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Wm. H. Fuqua (Fuqua)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/11/1868

8. AGE: Years	Months	Days	If less than one day
76	10	23	hr. min.

9. Birthplace Russell Field, Ky. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Wm. Fuqua
13. Birthplace Ky.

MOTHER
14. Maiden Name Anna Johnson
15. Birthplace Ky.

16 (a) Informant Mrs. Gladys Floyd (Daug).
(b) Address 1438 Mountmor Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory Lincoln
Location Lincoln, Ill.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Date received 10/9/45 Registrar for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/45 19 , at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4- 1945 to 10-3 1945, and that I last saw h[illegible] alive on 10/3 1945.

Immediate cause of death
Hypostatic Pneumonia, Cerebral Hemorrhage

	Duration
Due to	
	1
Due to	
	Mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. N. Wallace
Address 1725 Park Date signed 10/5/45 (M) (D)

VS 150

G32934 ✓ G32934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 W. Lefington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Erwin L. Bright

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 220 07 7948

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 1905

8. AGE: Years	Months	Days	If less than one day
40	5		hr. min.

9. Birthplace PORTSMOUTH VA. (Town, county, and state)
10. Usual Occupation TRUCK DRIVER
11. Industry or business OIL TRUCK

FATHER
12. Name GEORGE W. BRIGHT
13. Birthplace VA.

MOTHER
14. Maiden Name MINNIE WIGGINS
15. Birthplace VA.

16 (a) Informant JOHN R. BRIGHT (BROTHER)
(b) Address DUNDALK MD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 5/45 (month) (day) (year)
(c) Cemetery or crematory ST. MATTHEW
Location ODONNELL ST.

18 (a) Funeral director Lilly & Zeleen Inc.
(b) Address 403 S. WOLFE ST.

19 (a) Date received by local registrar OCT 5 1945 Huntington Hollins

VS 451

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1945, at 6 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Cholelithiasis

Due to

Other Conditions Fatty degeneration of Liver.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial [redacted] public place? While at work?
(d) Means of injury

23. Signature Robert L. Gutzeit M.D.
Medical Examiner.
Date signed Sept. 20 1945

X

G32935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G32935 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlevie St.
(c) Hospital or institution: St Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 de
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Sadtler

3 (b) If veteran, name war

(c) Social Security Account No. 217-22-9779

4. Sex	5. Color or race	6 (a) Single, married, widow or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1898

8. AGE: Years	Months	Days	If less than one day
47	8	27	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Sadtler
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Anna Sadtler
(b) Address 2711 Fait ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John T. Dunn
(b) Address 2869 Hudson St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 OCT 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1945 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-3 1945, and that I last saw him alive on 10-3 1945.

Immediate cause of death	Duration
Cerebral-Vascular accident	
Due to Hypertensive C.V.D	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H.E. Robertson M. D.
Address St Josephs Hosp Date signed 10-3-45

G32936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G32936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4229 Nicholas Ave.
(c) Hospital or institution:

26 - 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4229 Nicholas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Emrich

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine Emrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1875

8. AGE: Years	Months	Days	If less than one day
70 67	3	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Henry Emrich
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Elizabeth ----
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Katherine Emrich
(b) Address 4229 Nicholas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) Oct 5 1945 (Date received by registrar) Herwig for Williams M.P. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3rd. 1945 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 19 45 to Oct 3 19 45, and that I last saw h[illegible] alive on Oct 3 19 45.

	Duration
Immediate cause of death Coronary Failure	4 days
Due to Coronary Thrombosis	1 yr.
Due to Arteriosclerosis (Soft Blocks)	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S Bailey
Date signed Oct 4/45

VS 150

X

G32937

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G32937
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL 13-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 HRS.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 ROLAND AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME [redacted] (LARUE) LEAHEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife JOHN FRANCIS LEAHEY
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) APRIL 3, 1926

8. AGE: Years	Months	Days	If less than one day
19	5 6	0	— hr. — min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business —

FATHER
12. Name WALTER S. KELBAUGH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name THELMA MULLEN
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. THELMA KELBAUGH
(b) Address 3628 ROLAND AVE., BALTO., MD.

17 (a) Burial (b) Date thereof OCT 6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location

18 (a) Funeral director Thomas F. Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) OCT 5 1945 (b) Huntington Williamsport, MD
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 3, 1945 at 9:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 2, 1945 to OCT. 3, 1945 and that I last saw HER alive on OCT. 3, 1945.

Immediate cause of death	Duration
STROKE	
Due to DIABETIC COMA	
Due to DIABETES MELLITUS	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Wm. T. Speed III
Address Union Mem. Hosp. Date signed 10/4/45 M.D.

X

Ex. Wallis
5274 Park Heights Ave
632938

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. 632938

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 W 37th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 W 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen A. Bateman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widow.

6 (b) Name of husband or wife Alfred W. Bateman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 26 1876

8. AGE: Years	Months	Days	If less than one day
69	1	9	hr. min.

9. Birthplace Sweden.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER	12. Name Unknown.
	13. Birthplace Unknown.
MOTHER	14. Maiden Name Unknown
	15. Birthplace Unknown.

16 (a) Informant Harold Bateman
(b) Address 295 W 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Arlington
Location Harford Co. Md.

18 (a) Funeral director Edmonds & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) OCT 5 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Oct 4 1945, and that I last saw her alive on Oct 4 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Hemiplegia
Due to Arteriosclerosis
Due to Stroke
Other Conditions Myocarditis — 6 mos
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury
23. Signature Charles J. Bruce, M.D.
Address 5276 Park Heights Ave Date signed Oct 5 45

VS 150

X

G32939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G32939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Bacigalupa

3 (b) If veteran, name war No

3 (c) Social Security Account No. no

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anthony A. Bacigalupa | 6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1872

8. AGE: Years 73 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Home work at

11. Industry or business Home

FATHER 12. Name Blank [redacted]

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr. Anthony A. Bacigalupa

(b) Address 1212 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8, 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location 1430 Belair Rd.

18 (a) Funeral director Eugene W. Conklin & Son

(b) Address 924 E. Eager St.

19 (a) OCT 5 - 1945 (b) Registrar

Date rec'd by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3rd, 1945, at 8.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3, 1942, to Oct. 3, 1945, and that I last saw h[er] alive on Sept. 20, 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cassano M. D.

Address 514 Drury Lane Date signed 10/4/45

VS 150

63294-0

CMK-96291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

63294-0

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N. Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27-1905

8. AGE: Years	Months	Days	If less than one day
40	2	5	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Simpson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Marion Ada
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-5-'45 (month) (day) (year)
(c) Cemetery or crematory Burgaw
Location Burgaw N. C.

18 (a) Funeral director Mrs. Rafie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Filed (Date received by registrar) OCT 5 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945 to Oct. 2 1945, and that I last saw her alive on Oct. 2 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis Tuberculous Enteritis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert L. Copeland M.D.
Address Balto. City Hosp. Date signed 10/3/45

VS 150

Dr. Silvio Alessi
6100 Bk Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 6329-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 Fleetwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Fleetwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad Bauer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emilia Bauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1890

8. AGE: Years	Months	Days	If less than one day
55	6	-- 1	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Emilia Bauer
(b) Address 2817 Fleetwood Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Puck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

VS 150
OCT 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 3 1945, and that I last saw h. alive on Oct 3 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hrs.
Due to Hypertensive cardiovascular renal disease — 8 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 6217 Harford Ave Date signed 10/4/45

Huntington Woods, Mich.

Dr. Smauel Wolfe
1331 E. North Ave.

63,942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146E

63,942 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3119 Royston Avenue-14-
(c) Hospital or institution:

27-5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14- (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Royston Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph L. Chason, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Ella M. Chason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	--	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph L. Chason, S
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Ella M. Chason
(b) Address 3119 Royston Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1945 to Oct 3 1945 and that I last saw h[illegible] alive on Oct 3, 1945.

Immediate cause of death: Carcinoma of Sigmoid Colon

Due to: Metastatic Carcinoma of Liver

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 5 1945

Major findings of operation: Carcinoma of Colon

of autopsy:

Duration: 6 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B Wolfe

Address 1331 E North Ave Date signed 10-4-45 M. D.

X

G32943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G32943 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Madison Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Madison Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Howard E. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widowed

6 (b) Name of husband or wife Estella O. Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1871

8. AGE: Years	Months	Days	If less than one day
70	6	27	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business

FATHER
12. Name Rev. Alfred Young
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Emma Carpenter
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles Young
(b) Address 2401 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Int. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Low
(b) Address 202-04 Madison Ave.

19 (a) OCT 9 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1945, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945, to Oct 3 1945, and that I last saw h. alive on Oct 3 1945.

Immediate cause of death Hypostatic Pneumonia — Duration 2 days
Due to Lymphosarcoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Eustace Penn M. D.
Address 808 N. Fremont Ave. Date signed

X

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

632944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 W 14
(c) Hospital or institution: The Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4706 Roland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Allen STRATFORD Bowie

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 705-12-1499

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Ruth Calloway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1884

8. AGE: Years 60 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Howard S Bowie
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Bradley
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 6 1945 (month) (day) (year)
(c) ~~Cemetery or~~ crematory Greenmount
Location Balto Md

18 (a) Funeral director Kenny W Jenkins Funeral
(b) Address McCulloh & Eutaw Sts

19 (a) OCT 5 (b) Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1945 to Oct 4 1945 and that I last saw ~~her~~ alive on Oct 4 1945.

	Duration
Immediate cause of death Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: Autopsy - Sclerotic Heart Disease	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Fitzpatrick, Jr. M. D.
Address Union Memorial Hosp Date signed 10-4-45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G32945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 North Chapel Gate
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 North Chapel Gate (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN WOODWARD HAZELL

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary A. Hazell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1871

8. AGE: Years 74 | Months 8 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Millington Kent Co. Md. (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Benjamin M Hazell
13. Birthplace Millington, Kent Co. Md.

MOTHER
14. Maiden Name Elizabeth Boyer
15. Birthplace Kent Co. Md.

16 (a) Informant Miss Helen W. Hazell
(b) Address 511 N. Chapelgate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Millington Cemetery
Location Kent Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address No. & Pa. Aves. Balto., Md.

19 (a) (Date received by registrar) OCT 5 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3/45 19... at 8:30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1945 to October 3, 1945, and that I last saw h LM alive on 10/3/45 19...

Immediate cause of death: acute pulmonary edema — Duration:

Due to: arteriosclerotic cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Davis M.D.
Address Medical Arts Building Date signed 10/3/45

VS 150

G32946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G32946 Registered No. 1119a

HD# 96078

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-1
(e) Length of stay in Baltimore (yrs., mos., or days) 18days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Stump (Rosie Stump) ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14,1945

8. AGE: Years	Months	Days	If less than one day
--	--	18	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Ford William Stump
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rosie David
15. Birthplace W. Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.(Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D. Registrar
Oct 3 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945 at 5:46 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1945, to Oct. 2 1945 and that I last saw her alive on Oct. 2 1945.

Immediate cause of death	Duration
respiratory failure	
Due to Diarrhea	7 days.
Due to	
tracheotomy	8 days.
Other Conditions Cleft palate	
hypoplasia of mandible	

(Include pregnancy within 3 months of death)

Date of operation tracheotomy 9/24/45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Morrison, Jr. M. D.
Address City Hosp. Date signed 10/3/45

VS 150

G32927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira + Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 W. Univ. Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Henry Dudley

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillie Gaines Dudley
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept 23 1885

8. AGE: Years 60 | Months 0+ | Days 11 | If less than one day: hr. min.

9. Birthplace Hartford Co Md (town, county, and state)
10. Usual Occupation Retired Banker
11. Industry or business

FATHER
12. Name Albert McLeod Dudley
13. Birthplace Va

MOTHER
14. Maiden Name Ada Tyler Hancock
15. Birthplace Va

16 (a) Informant Mrs Lillie G Dudley
(b) Address 839 W University Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Barton & Gore
(b) Address 2334 N Charles St

OCT 5 - 1945 (Date rec'd by registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1945 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1945 to 10/4 1945 and that I last saw h[illegible] alive on 10/4 1945

	Duration
Immediate cause of death: Pulmonary Edema	3 days
Due to (a) Cardiac Decompensation	6 mos
Due to (b) Coronary Disease	10 yrs
Due to (c) Arteriosclerosis C.V. Disease	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Address Md Geol. Date signed 10/4/45

VS 150

632928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

632928 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 W. Union Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Sadie Davis Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Kingsmand A. Handy
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March 22, 1876

8. AGE: Years	Months	Days	If less than one day
69	6	13	hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)
10. Usual Occupation home duties
11. Industry or business

FATHER
12. Name Francis A. Davis
13. Birthplace Md.

MOTHER
14. Maiden Name Sallie Long
15. Birthplace Md.

16 (a) Informant Edward F. Buffington
(b) Address 4207 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy
Location Pikesville, Md.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Huntington Woodlawn, Md.

VS 10 OCT 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1945; at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1945, to 10/5 1945 and that I last saw her alive on 10/4 1945.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Metastatic Carcinoma lung.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 10/5/45

48 63294 9 | 2.65

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 63294 9 | 181

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E 9th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doralyn Sue Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-42

8. AGE: Years	Months	Days	If less than one day
2.	10	17 14	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hyan Ward.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Madelin Foreman
15. Birthplace W. Va

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Dumbar, W. Va.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) Date rec'd by registrar OCT 5 - 1945 Huntington, William, Md.

Approved: Robt Lee Baxter MD for Dr. McNally

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945 at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Oct. 4 1945 and that I last saw h ed alive on Oct. 4 1945.

Immediate cause of death	Duration
toxemia	
Due to 2nd & 3rd degree burns	
Due to accident	
Other Conditions Curlings ulcer? (Include pregnancy within 3 months of death)	

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Oct. 1, 1945 at 3.45 P M
(c) Where did injury occur? Sparrows Point (City or town) Baltimore (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury fell into boiling vat

23. Signature Richard F. Kupfer M.D.
Address Johns Hopkins Hospital Date signed 10/4/45

VS 150

Scelenna M. Price

G32950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G32950 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redmond + Green Sts.

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 71 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3127 Virginia Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Scelenna M. Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife John H. Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25-1878

8. AGE: Years	Months	Days	If less than one day hr.	min.
66 67	11	8		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name Lewis Frey

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Sarah Van Frey.

15. Birthplace Baltimore Md.

16 (a) Informant John H. Price.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Baltimore

18 (a) Funeral director Mamie Cook Dyer

(b) Address 1600 N. North Ave.

19 OCT 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1945, at 4:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1945, to October 3 1945, and that I last saw her alive on Oct. 3 1945.

Immediate cause of death Respiratory Failure — Duration 2-3 wks

Due to Carcinoma of Rt. Breast — 1 yr.

Due to Metastases to Spine both lungs and vertebrae — 6-9 mos.

Other Conditions Hypothyroidism Bilateral.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melvin A. Johnson

Address University Hospital Date signed 10/3/45 M. D.

G32951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G32951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Walnut ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Walnut ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. Katherine Fosnot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George B. M. Fosnot deceased.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1867

8. AGE: Years	Months	Days	If less than one day hr.	min.
78	7	21		

9. Birthplace Baltimore Ind.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John George Jentner.
13. Birthplace Germany.

MOTHER
14. Maiden Name Anna Katherine Jentner
15. Birthplace Baltimore Ind.

16 (a) Informant Mrs Mabel E. Fosnot
(b) Address 604 Walnut ave

17 (a) Burial (b) Date thereof 10/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Baltimore

18 (a) Funeral director Mamie E. Syfer
(b) Address 1600 W. North Ave.

19 OCT 5 - 1945 (b) Huntington Williams M.D.
(Date rec'd by Local Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 2 1945, and that I last saw her alive on Sept 23 1945.

Immediate cause of death	Duration
Myocarditis	
Due to Arterio-Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Wm. Delany Thomas M. D.
Address 716 Med. Arts Bldg Date signed Oct 4/45

632952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

632952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? If yes, name country NO (Yes or No)

3 (a) FULL NAME Richard Scully

3 (b) If veteran, name war First World War

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1894

8. AGE: Years 51 Months 8 Days 19 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Tavern Owner

11. Industry or business

FATHER
12. Name Dennis Scully
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Skelly
15. Birthplace Baltimore, Md.

16 (a) Informant Helen Midford
(b) Address 2624 Matthew St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Oct 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co.

18 (a) Funeral director A. Raymond Evans
(b) Address 1421 E. Baltimore St

19 (a) Oct 5 1945 (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1945, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1945 to Oct 3 1945, and that I last saw him alive on Oct 3 1945.

Immediate cause of death Coronary Artery Occlusion — Duration 8 days.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Wheeler

Address South Balto. Gen Hosp Date signed Oct 3 '45

G32953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G32953 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3559 Third Street, Brooklyn
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3559 Third Street, Brooklyn
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (MAJOR) LEROY WESLEY KLIMM

3 (b) If veteran, name war: World #1 & #2
3 (c) Social Security Account No. 212-09-3892

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Leona Klimm
6 (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Oct. 28, 1897

8. AGE: Years: 47 | Months: 11 | Days: 5 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: Major
11. Industry or business: U.S. Army

FATHER
12. Name: Christian Klimm
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden Name: Christina Bearsch
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Leona Klimm - widow
(b) Address: 3559 Third Street

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine PK. Mausoleum
Location: BALTIMORE, MD.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE? & BROADWAY

19 (a) OCT 5 - 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

P. M.

20. DATE OF DEATH Oct. 2 1945, at 10.20

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1943 to Oct 2 1945
and that I last saw b— alive on 10/2 1945

Immediate cause of death: Coronary Thrombosis
Due to: Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Samuel Quinn M. D.
Address 203 Patapsco One Date signed

X

VS 190

G32954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G32954
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Cranston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Willing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1/1945

8. AGE:

Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Baltimore City, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James M Willing
13. Birthplace Md

MOTHER
14. Maiden Name Emma Mesick
15. Birthplace Md

16 (a) Informant James M Willing
(b) Address 4001 Cranston ave

17 (a) Removal (b) Date thereof Oct 5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Burial
Location Md

18 (a) Funeral director Welrish Funeral Home
(b) Address 2005 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1945, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1945, to October 4 1945, and that I last saw h-r alive on October 4 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caudill M. D.

Address Md. Gen Hosp Date signed 10-5-45

Washington-Williams, Registrar

VS 2945

G32955 ✓ G32955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp W
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Cleveland Duckett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Divorced

6 (b) Name of husband or wife Maratka Thompson 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Produce dealer
11. Industry or business

FATHER 12. Name James H. Duckett
13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Grimm
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Baker
(b) Address 1931 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory H. Barnes
Location Leland Md.

18 (a) Funeral director Harry A. Wilkes
(b) Address 401 6 Edmondson Ave

19 (a) (Date received by registrar) OCT 5 1945 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1945, at 8:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 3 1945

G32956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32956

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 618 Wildwood Pkwy

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 618 Wildwood Pkwy.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret M. Spicer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Hiram H. Spicer Jr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1890

8. AGE: Years	Months	Days	If less than one day
55	5	4	hr. min.

9. Birthplace Balto. Md

(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER

12. Name Chas. L. Lowery

13. Birthplace Md

MOTHER

14. Maiden Name Rebecca M. Laysville

15. Birthplace Md

16 (a) Informant Hiram H. Spicer Jr

(b) Address 618 Wildwood Pkwy

17 (a) Burial (b) Date thereof Oct. 6/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Little

(b) Address 4101 Edmondson Ave

19 (a) Oct 5 1945 (b)

(Date received by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1/45. 19 , at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 45 to Sept 30 19 45

and that I last saw her alive on Sept 30 19 45

Immediate cause of death Coronary thrombosis — Duration 10 days

Due to

Due to

Other Conditions Hypertension — 4 yrs.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Geo. E. Wells M. D.

Address 4100 Edmondson Ave Date signed 10/2/45

X

632957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 632957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 314 S Mount St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 314 S. Mount St

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Johanna Schwenk

3 (b) If veteran, name war: /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Wilhelm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1858

8. AGE: Years	Months	Days	If less than one day
87	5	1	hr. min.

9. Birthplace Germany

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name — Gretzinger

13. Birthplace Germany

MOTHER

14. Maiden Name —

15. Birthplace Germany

16 (a) Informant Wilhelm Bronnenmeyer

(b) Address 314 S. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10. 6. 45 (month) (day) (year)

(c) Cemetery or crematory St. Pauls

Location Joh + Coolidge Ave.

18 (a) Funeral director Harry N. Witzke

(b) Address 4101 E Monument Ave.

19 (a) OCT 5 - 1945 (Date received by registrar) (b) Registrar

Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1945, at 1030 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1941, to Oct 1 1945, and that I last saw her alive on Oct 1 1945.

Immediate cause of death Arterio-sclerotic Cardio-Vascular Renal Disease

Duration
?

Due to

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?

(e) Means of injury —

23. Signature Carey Rostberg

Address 326 N Lombard St Date signed 10/4/45 M. D.

X

G32958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3415 Charles

(c) Hospital or institution: Greenway Apts

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3415 Charles St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roberta Codling Gantt

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles S Gantt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30 1871

8. AGE: Years 74 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER — 12. Name John L Codling

13. Birthplace England

MOTHER — 14. Maiden Name Daniel Wilson

15. Birthplace Baltimore Md

16 (a) Informant Charles S Gantt

(b) Address Greenway Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 6 45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilson Colton Son

(b) Address 1319 E Fort Ave

19 (a) OCT 5 1945 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940, to Oct. 4, 1945. and that I last saw him alive on Oct. 4, 1945.

	Duration
Immediate cause of death Apoplexy cerebral	
Due to Arteriosclerosis	
Due to	
Other Conditions General inanition	

(Include pregnancy within 3 months of death)

Date of operation 1940

Major findings of operation Obstruction intestinal

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arthur G. Barrett M. D.

Address Greenway Apts. Date signed Oct 5 1945

VS 150

G32959 C32757 G32959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York
(c) City or town North York (If outside city or town limits, write RURAL and give town)
(d) Street No. Laurel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Rohrbaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years 17 | Months | Days | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Joseph Rohrbaugh
13. Birthplace Pa

MOTHER
14. Maiden Name Edna Stanbaugh
15. Birthplace Pa

16 (a) Informant Joseph Rohrbaugh
(b) Address 46 Laurel St York Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 5/45 (month) (day) (year)

(c) Cemetery or crematory York Pa
Location

18 (a) Funeral director J. M. Schindler
(b) Address York Pa

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 5 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945, at 10:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945 to Oct 4 1945, and that I last saw h[illegible] alive on 10-4 1945

Immediate cause of death	Duration
Respiratory failure	
Post-operative Hemorrhage brainstem & 3rd Ventricle right	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-4-45

Major findings of operation: Colloid tumor 3rd Ventricle. Right appendectomy

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Duncan Clark M.D.
Address University Hospital Date signed 10-6-45

X

G32960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G32960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Minutes
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore St. Joseph Hospital (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Williams Hargrave

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-45

8. AGE: Years	Months	Days	If less than one day
			hr. 20 min.

9. Birthplace St. Joseph Hospital Balto. Md. (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Theodore Robinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Mandie Williams
15. Birthplace Hardin Co. Iowa

16 (a) Informant Mandie Hargrave
(b) Address 2003 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Gilbert & Sons
(b) Address 1217 E. Fort Ave

19 (a) Date received (Registrar) (b) Huntington Williams, Registrar

OCT 5 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH -9-30- 1945; at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Injury thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Prematurity -

Due to

Abortion

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D. Medical Examiner.
Date signed 10-5-45

X

G32961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G32961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2857 Chesterfield Ave.
(c) Hospital or institution:

27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2857 Chesterfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA E. HUFF

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: John W. Huff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	28	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Turner Ainsworth
13. Birthplace W. Va.

MOTHER
14. Maiden Name Hanna Wilson
15. Birthplace Va.

16 (a) Informant Mrs. Marie E. Johnson
(b) Address 4218 Shamrock Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 6 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/5 19 42 Oct 4 19 45, and that I last saw h[illegible] alive on Oct 4 19 45.

Immediate cause of death Carcinoma Larynx — Duration 1 day
Due to Carcinoma Pulmonary — 3 yrs
Due to
Other Conditions age
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. S. Bagley, Charles Bx & Balto Co Date signed 10/5/45

X

G32962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G32962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Charles & 34th Sts.
(c) Hospital or institution: Cambridge Arms Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2 Charles & 34th Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: MARGARET M. WOHNLICH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick P. Wohnlich
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1875

8. AGE: Years: 70 | Months: 0 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Detroit, Mich. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Henry McColl
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Anna --
15. Birthplace: --

16 (a) Informant: Mr. B. Franklin Hearn, Jr.
(b) Address: 312 Broadmoor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) OCT 6 (b) 1945 Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 4 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1929 to Oct 4 1945 and that I last saw h[er] alive on Oct 4 1945

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Wethered Lee Foot
Address: 20 E. Preston St. Date signed: 10/4/45

VS 150

Wethered Lee Foot

G32963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G32963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sedonia A. Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1903

8. AGE: Years	Months	Days	If less than one day
42	-	3	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jerry Blackwell
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Campbell
(b) Address 1110 N. Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George D. Wilson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by local registrar) (b) Huntington Williamsport Md

OCT 6 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1945, at 10 45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured appendical abscess; generalized peritonitis; liver abscess

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct 3 1945

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

632964 / 94 B / Registered No. 632964

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Beverly Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Beverly Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles L. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Mary F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9-1872

8. AGE: Years	Months	Days	If less than one day
73	0	25	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name Charles L. Smith
13. Birthplace North Carolina

MOTHER
14. Maiden Name unknown Williams
15. Birthplace North Carolina

16 (a) Informant Marian H. Smith
(b) Address 3208 Beverly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. End of North Ave.

18 (a) Funeral director Dulaney Cook Inc.
(b) Address 1217 Cathedral St

19 (a) (Patient's hospital) (b) Registrar
OCT 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1945 at 4.00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Angina Pectoris.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 10/5/45

G32965

SHERIDAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No. G32965

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Penna, ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Penna ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sheridan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Baltimor City (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Rasin Sheridan

13. Birthplace Balto. Md

MOTHER 14. Maiden Name Margrit Gordan

15. Birthplace Baltimor Md

16 (a) Informant Rosa Upshur

(b) Address 1100 Penna, Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Baltimore Md

18 (a) Funeral director Frances A Hemler

(b) Address 574 W Biddle St

(Date rec'd) OCT 6 - 1945 (Registrar's signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1945 to Oct 4 1945, and that I last saw h[illegible] alive on Oct 4 1945

Immediate cause of death: apoplexy — Duration Sudden

Due to: Mitral Insufficiency

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1 E Monument Date signed 10/6/45

VS 150

X

G32966

CWK-94001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32966
Registered No. 101

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-3-28
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Madison Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Frisby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Horace Frisby
13. Birthplace ?

MOTHER
14. Maiden Name Ellen ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hoffman
(b) Address 1631 Druid Hill Ave.

19 (a) Date filed Oct 6 1945 (b) Thurlington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 19 45 at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1945, to Oct. 2 1945, and that I last saw him alive on Oct. 2 1945.

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to
Due to
Other Conditions Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)
Date of operation 9-30-45
Major findings of operation: Enlarged abdominal lymph nodes
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps. Date signed 10-4-45

X

G32967
479988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

113 B

Registered No. G32967

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joyce Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-44

8. AGE: Years	Months	Days	If less than one day
1	13 1	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wade Jenkins

13. Birthplace Va

MOTHER 14. Maiden Name Edith J Thuson

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Jamesa Adams

(b) Address 142 W Saratoga St

OCT 6 - 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5- 1945 at 5.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 7 1945 to Oct- 5 1945 and that I last saw h[illegible] alive on Oct- 5- 1945

Immediate cause of death: Miliary Tuberculosis — Duration: 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury

23. Signature Warren M. Quattlebaum M. D.

Address 946 E. Date signed 10-5-45

Warren M. Wiesel

SORRELL

G32968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246

Registered No. G32968

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry L. Sorrell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1881

8. AGE: Years 64 | Months . | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Garner
13. Birthplace Balto

MOTHER
14. Maiden Name Jenny Sorrell
15. Birthplace Balto

16 (a) Informant Anna Sorrell
(b) Address 916 Edmondson Ave

17 (a) Burial (b) Date thereof 10-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L. Brown Son
(b) Address 108 W Montgomery St

OCT 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 — 1945, at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 — 1945 to 10-3-1945, and that I last saw him alive on 10-3-1945.

Immediate cause of death: Bronchitis, Ind — Duration 3 mos
Due to: Cerebrosis of Liver — 3 mos
Due to: Encephalitis Ind Jaundice
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas R. Blake M. D.
Address 1327 N. Central Ave Signed 10-5-45

6329 69

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 6329 69

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Plum alley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Plum alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Garnett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Wm J Garnett
13. Birthplace Va

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Va

16 (a) Informant James Jones
(b) Address 109 Hughes Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A.Co. Md

18 (a) Funeral director Isaiah D Brown Son
(b) Address 108 W Montgomery St Balto

19. Date rec'd by local registrar OCT 6 - 1945
(b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 3 1945, at 7 45 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10-4-45

VS 151

X

63290 BALTIMORE CITY HEALTH DEPARTMENT 55E Registered No. 63290

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 142 days
(e) Length of stay in Baltimore (yrs., mos., or days): 142 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Florida (b) County:
(c) City or town: Pensacola (If outside city or town limits, write RURAL and give town)
(d) Street No.: 321 W. Baylam St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country:

3 (a) FULL NAME: Mc Graw, James

3 (b) If veteran, name war:
3 (c) Social Security Account No.: 263-22-8233

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	3	hr. min.

9. Birthplace: Portland, Maine (Town, county, and state)
10. Usual Occupation: Cook
11. Industry or business: Seafarer

FATHER
12. Name: James Mc Graw
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Helen Tobins
15. Birthplace: Nova Scotia, Canada

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/1945 (month) (day) (year)
(c) Cemetery or crematory: Loreno Prospector Corp
Location: Odar Funeral Home Inc

18 (a) Funeral director: 4644 York Rd.
(b) Address:

19 (a) Date received: OCT 10 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 4 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1945, to Oct. 4 1945, and that I last saw him alive on Oct. 4 1945.

Immediate cause of death	Duration
Malignant melanoma (primary right foot) metastasis to	more than 2 yrs.
Due to: intestines, lungs and brain.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: May 22, 1945
Major findings of operation: Amputation of right leg
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J. L. Wilson
J. L. Wilson, Sr. Surgeon, USPHS M.D.
Address: U.S. Marine Hospital, Balto., Md. Date signed:

G32971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G32971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22

(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore, Govanstown (If outside city or town limits, write RURAL and give town)

(d) Street No. 2804 Page Drive (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Caroline Marie Todd

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/12/45

8. AGE: Years — Months — Days 23 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business —

FATHER 12. Name Robert Todd.

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Dorothy Sumpter

MOTHER 15. Birthplace Maryland

16. (a) Informant Dotty Todd

(b) Address 2804 Page Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Edmondson Ave

18 (a) Funeral director John G Connelly

(b) Address 419 Eastern Ave. Embalmer 21 yrs

19 OCT 17 - 194- (Date rec'd by registrar) (b) Huntington Mills

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945 at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1945 to 10/6 1945, and that I last saw h[illegible] alive on 10/5 1945.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration
23d.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature David [illegible] M. D.

Address Mercy Hospital Date signed 10/16/45

VS 150

G32972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

G32972

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Eisler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Violet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1901

8. AGE: Years 43 (45) | Months 11 | Days | If less than one day hr. min.

9. Birthplace Myersdale Pa. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Meth. Shipbuilding Co

FATHER
12. Name Wm. H. Eisler
13. Birthplace Sandpatch Pa.

MOTHER
14. Maiden Name Lydia Fitch
15. Birthplace Sandpatch, Pa.

16 (a) Informant Walter E. Eisler
(b) Address 325 S. Kimberly Ave, Apt. Pa.

17 (a) Burial Record (b) Date thereof Oct. 6, 1945 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory
Location TENNYSBORO, W. Va.

18 (a) Funeral director Charles E. Delozier
(b) Address Ellicott City

10 CT 7 - 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 2nd & 3rd degree burns involving 80% body surface

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-5-45 at 3:15 A. M. 6/2
(b) Where did injury occur? 2508 Fairmount Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 10-6-45

VS 151

G32973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G32973

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 516 Mc Mechen St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 516 Mc Mechen St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Gertrude Crosby

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Fred Crosby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/95

8. AGE: Years	Months	Days	If less than one day
50	3	19	hr. min.

9. Birthplace Balto. Md.

(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Alexander Russell

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Clara Gardner

15. Birthplace Balto. Md.

16 (a) Informant Thelma Stammore

(b) Address 516 Mc Mechen St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)

(c) Cemetery or crematory St. Peters

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 312 N. Schroeder St,

(b) Huntington Williams, M.F

Registrar

Oct 9 1945

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945, to Oct 4 1945, and that I last saw her alive on Oct 3 1945.

Immediate cause of death	Duration
Cardio Vascular Renal Disease	6 mo's
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. William Frey M. D.

Address 318 Penna Ave Date signed 10/5/45

VS 150

X

G32974 G32974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Pearce Street
(If rural give location)
(e) Citizen of foreign country? Pitts (Yes or No)
If yes, name country

3 (a) FULL NAME James Wilkens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Laura Wilkens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wesley Wilkens
13. Birthplace Md.

MOTHER
14. Maiden Name Marita Wilkins
15. Birthplace Md.

16 (a) Informant Mary Fankard
(b) Address 931 Pierce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R Wilkins
(b) Address 322 N. Schroeder St. Huntington Pittsville, Md.

19 (a) Date rec'd by registrar 10-5-45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure
Acute Pulmonary Edema & Emphysema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 10-3-45

VS 151

G32975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G32975

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 Brune St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 2
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 Brune St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary E Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George W. Morris
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Josephine Rudd.
(b) Address 518 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 315 N. Schroeder St. Huntington Williams, W.Va.

19 (a) OCT 9 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 1945 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1945 to 10-2 1945, and that I last saw h.. alive on 10-2 1945

Immediate cause of death	Duration
Cardio-Renal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. F. Hatcher

Address 2 S Paca St Date signed 10/5/45 M. D.

VS 150

X

G32976 ✓ X S/S. "Harbour" G32976

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich (b) County
(c) City or town Read City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. (L.) Morris

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1889

8. AGE: Years	Months	Days	If less than one day
56	6	19	hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Mary J. Tracey
13. Birthplace Ire.

MOTHER
14. Maiden Name Fred B. Morris
15. Birthplace Res Delaware Mich -

16 (a) Informant Fred B. Morris
(b) Address Read City, Mich

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Read City Michigan

18 (a) Funeral director Young & Tarleton
(b) Address Tarleton & Fayette

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport

OCT 7 VS 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945, at 8 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-4- at 26/6 8 M.
(b) Where did injury occur? Harbor - Foot of Clinton St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Fell into harbor.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-5-45

G32977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G32977 Registered No.

HB #69060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2mos. 13days
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Saratoga St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McCoy William

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Martha(d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	8	19	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name McCoy Pen
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Buck
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave. (Records)

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-6-45 (month) (day) (year)
(c) Cemetery or crematory Hopewell Cemetery.
Location Lynchburg Va

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave. S.E. Wash. D.C.

19 (a) 10-6-1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1945 at 9:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1944 to Oct. 2 1945 and that I last saw him alive on Oct. 2 1945

Immediate cause of death Cardiac Failure

Due to Hypertension in cardio vascular disease

Due to

Other Conditions Emphysema of contributed arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. H. Copeland M. D.
Address Date signed 10/4/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G32978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G32978

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hos
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Kenny
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 1906

8. AGE: Years	Months	Days	If less than one day
39	May	0	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name Michael J. Kenny
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Kelly
15. Birthplace Balto.

16 (a) Informant Blanche Kenny
(b) Address 1600 Hollins

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1945 (month) (day) (year)
(c) Cemetery or crematory Gatheridge
Location 4300 Old Frederick Road
18 (a) Funeral director Martin J. Conroy
(b) Address 1600 Hollins St

19 (a) (Date filed by registrar) (b) Registrar

OCT 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945 at 12:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945 to 10/6 1945
and that I last saw h[illegible] alive on 10/5 1945

Immediate cause of death Peripheral Circulatory Collapse — Duration 2 day.
Due to Paralytic Ileus
Due to Post Operative for Volvulus of Bowel.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9/22/45
Major findings of operation: Volvulus of Bowel
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Chas. Norton, Jr. M. D.
Address Bon Secours Hosp Date signed 10/6/45

G32979 Haverstadt

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G32979

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2516 W Fairmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 W Fairmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Haverstadt
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 21 1886

8. AGE: Years	Months	Days	If less than one day
60	6	15	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name William Haverstadt
FATHER 13. Birthplace Germany.

MOTHER 14. Maiden Name Dont. know
MOTHER 15. Birthplace Germany.

16 (a) Informant Marie Haverstadt
(b) Address 2516 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road

18 (a) Funeral director Martin J Conroy
(b) Address 1610 Hollins st

19 (a) Date rec'd [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1945 to 10/5 1945 and that I last saw him alive on 10/5 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 hrs
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Cahn M. D.
Address 2145 W Balto Date signed 10/6/45

VS 180

G32980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G32980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 East Baltimore Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 East Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX LINDE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Martha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Aaron-
13. Birthplace Russia

MOTHER
14. Maiden Name Emma
15. Birthplace Russia

16 (a) Informant Un. Linde
(b) Address 3058 Idaho Ave, N.W. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Jack Lewis Inc
18 (a) Funeral director E. Balto. St
(b) Address 1439
19 (a) OCT 7 - 1945 (Date rec'd by registrar) (b) Huntington Cemetery, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6/45 19 , at 12:40 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 10/6/45

G32981 ✓ G32981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Loyola Northway
(c) Hospital or institution: 15 or 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36y 6m 2d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 Loyola Northway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Hyman Oppel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Miriam Oppel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Rev.

11. Industry or business

FATHER
12. Name Israel Moses Oppel
13. Birthplace Russia

MOTHER
14. Maiden Name Muglis
15. Birthplace Russia

16 (a) Informant Miriam Oppel
(b) Address 2614 Loyola Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-45 (month) (day) (year)
(c) Cemetery or crematory Lizedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto. St Huntington Williams, Mgr.

19 (a) 10-7-1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-45 19 , at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 10-5 1945, and that I last saw him alive on 10-5-45 19

Immediate cause of death Acute coronary thrombosis
Duration 2 hrs
Due to arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Meyer Bloch M.D.
Address 2904 Rexter Rd Date signed 10-7-1945

G32982 ✓ G32982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Oswego Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Oswego Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Hankin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER 12. Name: Laiba Hankin

13. Birthplace: Russia

MOTHER 14. Maiden Name: Badane ?

15. Birthplace: Russia

16 (a) Informant: Nathan Hankin

(b) Address: 2624 Oswego Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7/45 (month) (day) (year)

(c) Cemetery or crematory: Hebrew Rosedale

Location: Hamilton Ave.

18 (a) Funeral director: Sol Levinson &Bros

(b) Address: 1124 26 W. North Ave.

(a) Date received by registrar: OCT 7 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 1op. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1945 to Oct 6 1945 and that I last saw h. alive on 10/6 1945.

Immediate cause of death: Bronchopneumonia — Duration: 24 hrs.

Due to

Due to

Other Conditions: Arteriosclerosis, Prostatic Obstruction — 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Louis Blum, M.D.

Address: 2310 Eutaw Pl. Date signed 10/9/45

X

G32983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 BG32598

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 Merrymount Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Merrymount Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Fitzgerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John J. Fitzgerald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/88

8. AGE: Years 57 | Months 4 3 | Days 6 24 | If less than one day: hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation home duties

11. Industry or business

FATHER
12. Name Patrick J. Quigley
13. Birthplace Canada

MOTHER
14. Maiden Name Hannah R.
15. Birthplace Rochester, N. Y.

16 (a) Informant Mr. Wm. F. Doyle
(b) Address 19 Merrymount Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory Calvery Cemy.
Location Pttsburg, Pa.

18 (a) Funeral director John O. Metzdorff Funeral
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

OCT 7 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1945, at 6.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944, to Oct 6 1945, and that I last saw her alive on Oct. 6 1945

Immediate cause of death: Carcinoma of uterus — Duration: 5 years

Due to:

Due to:

Other Conditions: Recurrence + abdominal metastasis after — 16 mo +
(Include pregnancy within 3 months of death)

Date of operation: Hysterectomy - 1940

Major findings of operation: carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawson Watkins M. D.

Address 501 Edgevale Road Date signed Oct 7, 45

X

G32984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G32984
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia Pa. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2841 Germantown Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sadie Mulhern

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Milliner
11. Industry or business

FATHER
12. Name Thomas Mulhern
13. Birthplace Ireland

MOTHER
14. Maiden Name Honor McLaughlin
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Sherwood Memorial Co.
(b) Address 108 W Franklin St.

(a) (Local registrar) (b) Huntington Williamsport, Md.

OCT 7 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1934 to Oct. 6 1945, and that I last saw h.er alive on Oct 6 1945

Immediate cause of death	Duration
Repeated coronary thrombosis	4 mo.
Due to	
Due to	
Other Conditions Schizophrenia	25 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent P. Calagna M. D.
Address 3326 Liddesdale Rd Date signed

G32985 BALTIMORE CITY HEALTH DEPARTMENT G32985

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) CAMBRIDGE ARMS APTS.
(d) Street No. CHARLES & 34TH (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME ~~MRS. CHARLES~~ (MARY) PLAYFORD (MARY Graham Vickery Playford)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife CHARLES PLAYFORD

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) DEC. 28, 1876

8. AGE: Years 68 | Months 9 | Days 8 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER
12. Name EDWARD M. VICKARY
13. Birthplace MARYLAND - Balto.

MOTHER
14. Maiden Name AUGUSTA HENDERSON
15. Birthplace ~~MARYLAND~~ London-England

16 (a) Informant HUSBAND (Charles Playford)
(b) Address CHARLES & 34 STS.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. City - Md.

18 (a) Funeral director Stewart Mowen Co.
(b) Address 108 W. North Ave - City

19 (a) OCT 9 1945 (Date received by registrar) (b) Registrar

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 6, 1945 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3, 1945 to Oct. 6, 1945 and that I last saw her alive on Oct 6, 1945

	Duration
Immediate cause of death SHOCK	
Due to CEREBRAL HEMORRHAGE	
Due to ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR DISEASE & left ventricular failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Wm. L. Sprad. M.D.
Address Union Memorial Hosp. Date signed 10/6/45

X

G32986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1950

G32986 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore/Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Sudbrook Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baine Wistocki (Emma Baine Wistocki)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Guy C. Wistocki
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept. 21-1882

8. AGE: Years 63 | Months 0 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name William Goodson
13. Birthplace Virginia

MOTHER
14. Maiden Name Kathryn Thompson
15. Birthplace Virginia

16 (a) Informant Mr. Clark L. Wisotzki (Son)
(b) Address 528 Sudbrook Ave - Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Evergreen Cemetery
Location Gettysburg - Penna

18 (a) Funeral director Stewart Mason Co.
(b) Address 108 W Lanvale

19 (a) 10-7-1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945 at 7 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/23 1945 to 10/6 1945 and that I last saw her alive on 10/6 1945

Immediate cause of death	Duration
Hypostatic Pneumonia.	
Due to Hypertension, Cardio-Vasc. Ren. Disease & Congestive Heart failure	
Due to	
Other Conditions Carcinoma of Breast & generalized Metastases	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address St Agnes Hosp Date signed 10/8/45

G32987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G32987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Linden & Madison

(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1523 Friendship St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Jack R. Bruff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27th 1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore City, Md.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarence R. Bruff

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Katherine R. Broadbelt

15. Birthplace Balto. Md.

16 (a) Informant Katherine R. Bruff

(b) Address 523 Friendship St

17 (a) Burial (b) Date thereof 10/9/45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Md

18 (a) Funeral director Williams Bok Inc.

(b) Address 1217 St. Paul St.

19 (a) 10-7-1945 Huntington Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 6 1945. and that I last saw h alive on Oct 5 1945

Immediate cause of death Terminal Pneumonia

Due to

Due to

Other Conditions Diarrhea

Icterus Neonatorum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia, staph aur lobar

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature C. M. Conelli M. D.

Address Md. Gen. Hosp., Date signed 10-6-45

VS 190

G32938 BALTIMORE CITY HEALTH DEPARTMENT G32988

CERTIFICATE OF DEATH 927

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 N North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 N North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Sarah A Goldsmith

3 (b) If veteran, name war W
3 (c) Social Security Account No. xxx

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank J Goldsmith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1872

8. AGE: Years 73 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Norfolk Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Christopher A Windsor
13. Birthplace Va

MOTHER 14. Maiden Name Camille L Hall
15. Birthplace Va

16 (a) Informant Robert Goldsmith
(b) Address 2921 N North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 7 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1945, at 12 midnight M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1945, to Oct 5 1945, and that I last saw h[illegible] alive on Oct 5 1945.

Immediate cause of death Chronic Cardiac Decompensation — Duration 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest A Rahn
Address 1735 Poplar St Date signed 10/6/45 M.D.

VS 150

G32989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G32989 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Mount Royal Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Eliza Broaddus Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27th 1869

8. AGE: Years	Months	Days	If less than one day
76	5	9	hr. min.

9. Birthplace Virginia (Kempsville)
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Roland Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Virginia

16 (a) Informant Mrs. Robert M. Chapman
(b) Address 347 E. 22nd St, Balto. 18

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery Kempsville
Location Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (Date paid by registrar) (b) Huntington Williams

1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 at 12 19 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1945 to Oct. 6 1945 and that I last saw h.e.r. alive on Oct. 6 1945

Immediate cause of death Cerebro-vascular accident — Duration 4 days

Due to Hypertensive cardio-vascular disease

Due to Hard arterio-sclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Speed III

Address Union Memorial Hosp. Date signed 10/6/45 M.D.

X

G32990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G32990 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3607 Ninth St Brook
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Ninth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene F. Labatue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of husband Julia A Labatue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1872

8. AGE Years	Months	Days	If less than one day
73	8	19	hr. min.

9. Birthplace Apalachicola, Florida
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Foote Packing Co.

FATHER
12. Name Eugene Labatue
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Chas. Weir
(b) Address 3607 Ninth St. - Brooklyn

17 (a) Burial (b) Date thereof 10/8/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 19 45, at 4 40 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Rectum

Due to

Other Conditions Arteriosclerotic C.V. Disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Dalessandro M.D.
Medical Examiner.
Date signed 10/6/45

G32991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1212

G32991
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 816 N. 37th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 7
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 816 N. 37th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Joseph Fedler

3 (b) If veteran, name war

3 (c) Social Security Account No. 043-05-6250

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eliza Jane Fedler
6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) July 31 1887

8. AGE: Years 58 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y.
(City, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name	Adolph Fedler
FATHER 13. Birthplace	New York
MOTHER 14. Maiden Name	Annie Kellner
MOTHER 15. Birthplace	New York

16 (a) Informant Mrs. Eliza J. Fedler
(b) Address 816 N. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3031 Falls Road

19 (a) OCT 7 1945 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 19 1945 to Oct 4 1945 and that I last saw him alive on Sep 29 1945.

Immediate cause of death Cardio-Renal Disease — Duration 18 mo

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz J. Schnuer M. D.
Address 2700 Maryland Date signed Oct 4 1945

G32992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

G32992 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5602 Mattfeldt Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5602 Mattfeldt Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Catherine Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George H. Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21-1867

8. AGE: Years 77 | Months 11 | Days 14 | If less than one day: hr. min.

9. Birthplace Freeland Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Ole Matthewz
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Barwasser
15. Birthplace Germany

16 (a) Informant Mrs. Reuben L. Farman
(b) Address 5602 Mattfeldt Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Pablo Road

19 (a) OCT 7 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1945, at 10 M

21. I certify that death occurred on the date above stated that I attended deceased from Mar. 1 1945 to Oct 5 1945, and that I last saw h[illegible] alive on Oct 5 1945

	Duration
Immediate cause of death Coma	
Cerebral thrombosis	4 days
Due to Ruptured Berebric	
Cerebral artery	
Due to age	
Other Conditions Surgical Asst.	
Pneumonitis	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R Wantz M. D.
Address 2601 Manhattan Ave Date signed 10/6/45

G32993 BALTIMORE CITY HEALTH DEPARTMENT G32993
Registered No.

CERTIFICATE OF DEATH 1937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Aiken St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice B. Dudley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband ~~or wife~~: Robt. E. Dudley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21st 1864

8. AGE: Years 80 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patrick Caffrey
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Byrne
15. Birthplace Scotland

16 (a) Informant Miss Madeleine Dudley
(b) Address 3300 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) OCT 7 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5th 1945, at 1 30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941 to Oct 4 1945 and that I last saw her alive on Oct. 4 1945.

Immediate cause of death: Arteriosclerotic C V disease — Duration 5 yrs.
Due to: Coronary thrombosis — 2 hrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Strong M.D.
Address 1402 E. Lanvale St. M.D.
Date signed 10-6-45

X

G32994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G32994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hoffman & Caroline Sts.

(c) Hospital or institution: St. Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balto.

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3802 Mt. Pleasant Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MRS. LULA M. FOWLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Ernest Fowler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-5-1900

8. AGE: Years	Months	Days	If less than one day
45	10	1	hr. min.

9. Birthplace Baltimore, Balto., Md. (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin Lane

13. Birthplace Md

MOTHER 14. Maiden Name Alberta McMains

15. Birthplace Md

16 (a) Informant Ernest L Fowler

(b) Address 3802 Mt Pleasant Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10/45 (month) (day) (year)

(c) Cemetery or crematory Maryland Memorial Park

Location Balto Co Md

18 (a) Funeral director Wilmot Funeral Home

(b) Address 2008 W Baltimore St

(b) Date rec'd by Registrar OCT 7 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1945 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3, 1945 to Oct. 6, 1945, and that I last saw her alive on Oct. 6, 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Rheumatic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Mitral stenosis, congestion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. E. Wallace M. D.

Address 1400 W. Cadiz St Date signed 10-6-45

VS 150

G32995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G32995 Registered No. 140 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA FRETWELL

L 33198

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Ralph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1920

8. AGE: Years	Months	Days	If less than one day
24 28	9/10	4 3/7	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Western Elec Co
11. Industry or business Inspector

FATHER
12. Name Joseph Kunsky
13. Birthplace Michigan

MOTHER
14. Maiden Name Francis Mulvaul
15. Birthplace Md

16 (a) Informant Elroy Kunsky
(b) Address 507 S Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8/45 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Balto Md

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

OCT 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945, at 1:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Septicemia.

Due to Gangenous endometritis

Other Conditions Spontaneous abortion

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Raul A Foster M.D.
Medical Examiner.
Date signed October 6, 1945

G32996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G32996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 E. North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE AGNES FLOWERS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Robert W. Flowers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Dec. 6, 1869
8. AGE: Years 75 | Months 10 | Days 5 | If less than one day hr. min.
9. Birthplace: Harford County, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Abel A. Morris
13. Birthplace: Chester Co. Pa.

MOTHER
14. Maiden Name: Ann E. Alexander
15. Birthplace: Phila. Pa.

16 (a) Informant: Miss Lois Morris
(b) Address: 1209 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)
(c) Cemetery or crematory: Grace Evangelical Church
Location: Ervansville, Pa.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Signature and title of registrar) (b) Registrar

OCT 7 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945 at 3.05 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1945 to Oct. 4 1945 and that I last saw deceased alive on Oct. 4 1945.

Immediate cause of death: Carcinoma of Stomach — Duration 1 mo. 7 d.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. H. Krenzer M.D.
Address 1402 E. Lanvale Date signed 10.5.45 M. D.

X

G32997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G32997 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Carswell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Carswell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar H. Vetter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1884

8. AGE: Years	Months	Days	If less than one day
60 61	11	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Bar + Eliot Co.

FATHER
12. Name Ferdinand Vetter
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma Hammer
15. Birthplace Baltimore

16 (a) Informant Mrs Louise E. Vetter
(b) Address 1415 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1200 N. Lombard St

19 (a) (b)
(Date received by registrar) Registrar
OCT 7 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1945 Oct 4 1945
and that I last saw h alive on Oct 4 1945

Immediate cause of death	Duration
Coronary Thrombosis	10/4/45
Due to Ch. Myocarditis	Jan 1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Williams Roamer M. D.
Address 801 Kenilworth Dr Date signed 10/

G32998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G32998

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlton St.
(c) Hospital or institution: Mount Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo. 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Front St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby RUBY M. FESPERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife Father

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-29-45

8. AGE: Years	Months	Days	If less than one day
	3	7	hr. min.

9. Birthplace Balto. Balto. Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hugh C. Fesperman
13. Birthplace Stanly County N.C.

MOTHER
14. Maiden Name Loretta Gelinian
15. Birthplace Canada

16 (a) Informant (Mother)
(b) Address 115 N. Front St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-1945 (month) (day) (year)
(c) Cemetery or crematory St. Vincent
Location Belair Rd. Rose St.

18 (a) Funeral director Frank Della Nora
(b) Address 52 N. Morley St.

19 (a) Oct 8 1945 (Date received by registrar) (b) Registrar

Washington for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1945 at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1945 to Oct 6 1945 and that I last saw h[illegible] alive on Oct. 6, 1945.

Immediate cause of death Malnutrition and dehydration

Due to Hyperpyrexia and diarrhea

Due to Unknown cause.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congestion base of lungs

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M.D.
Address 1400 N Carlton St Date signed 10-7/45
M. D.

G32999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G32999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 838 N Augusta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 838 N Augustan (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine E. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Joseph C White
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1882

8. AGE: Years	Months	Days	If less than one day
62	10	20	hr. min.

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation Sales lady
11. Industry or business Dept Store

FATHER
12. Name Maurice McQuilliffe
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Conan
15. Birthplace Ireland

16 (a) Informant Mrs Zella C Estes
(b) Address 838 N Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frd. Rd
18 (a) Funeral director Harry H Weikel
(b) Address 4101 Edmondson Ave

19 (a) Date rec'd by Local Registrar OCT 8 - 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1945 at 8 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19, 1945 to Oct. 4, 1945 and that I last saw her alive on Oct. 4, 1945

Immediate cause of death Coronary Thrombosis — Duration
Due to Endocarditis and — 7
Due to Mitral Insufficiency
Other Conditions
(Include pregnancy within 8 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Georgia Kemp
Address 3030 Edmondson Ave. Date signed 10/4/45

633000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3 a

Registered No. 633000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 E. Eager Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA ELIZABETH FREDERICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1892

8. AGE: Years	Months	Days	If less than one day
53 yrs.	6	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Crispens
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise Freise
15. Birthplace Baltimore, Md.

16 (a) Informant William Frederick (husband)
(b) Address 2408 E. Eager Street

17 (a) Burial (b) Date thereof 10/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 OCT 8 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1944, to Oct. 4 1945 and that I last saw her alive on Oct. 2 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hour
Due to Hypertension	9 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Vincent H. Ioaka M.D.
M. D.
Address 845 N. Patterson Pk. Date signed 10/5/45

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G33001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. G33001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. OA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 568 Baker St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Howard P. Brooks

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W W I	218-10-1590	M	C	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 30, 1901

8. AGE: Years	Months	Days	If less than one day
44	-	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Chase
15. Birthplace Maryland

16 (a) Informant Mildred Fostine
(b) Address 568 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Balto Nat cem
Location Md

18 (a) Funeral director George B. Kelson
(b) Address 1202 Eastern Ave

19 OCT 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1945, at 2 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Oct. 5 1945

VS 151

G33002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Greenspring & Belvedere Aves.

(c) Hospital or institution: Levindale, Hebrew Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. Belvedere Ave (If rural give location) Levindale

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sam Lapides

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Morris

13. Birthplace Russia

MOTHER

14. Maiden Name Leah

15. Birthplace Russia

16 (a) Informant Dept Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem Pk

Location Lanes

18 (a) Funeral director Jack Levy Lee

(b) Address 1429 E. Balto St

19 (Date received by registrar) OCT 8 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5 1945 to 10-6 1945, and that I last saw h[illegible] alive on 10-6 1945.

Immediate cause of death Cardiovascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Levin, M.D.

Address Levindale Date signed 10/8/45

VS 180

MORRIS HOBMAN

G33003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G33003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2008 Brookfield Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Morris Hobman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER 12. Name —

13. Birthplace Russia

MOTHER 14. Maiden Name —

15. Birthplace Russia

16 (a) Informant Louis Hobman

(b) Address 2008 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Wash. Blvd.

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1739 E. Balto St.

19 (a) OCT 8 - 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1945, at 12:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1945 to 10-7 1945 and that I last saw him alive on 10-2 1945.

Immediate cause of death Bronchopneumonia — Duration

Due to Cancer of Lung

Due to

Other Conditions Hypertensive C.V.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Alvin D. Rubo M. D.

Address Sinai Hosp Date signed 10-9-45

VS 150

X

G33004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157F

Registered No. G33004

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Oakland Signal Apts #302 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bailey Reid Couch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Shipfitter
11. Industry or business

FATHER
12. Name Clyde Couch
13. Birthplace Johnson Co Ky

MOTHER
14. Maiden Name Hazel E Stobbs
15. Birthplace Lebanon Ky

16 (a) Informant Robert L Couch
(b) Address 302 Couch Hobbard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem
Location

18 (a) Funeral director Chas S Powell
(b) Address 1427 Edmondson Ave

19 OCT 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1945 to Oct 7 1945, and that I last saw alive on Oct 7 1945.

Immediate cause of death CARDIO-VASCULAR COLLAPSE — Duration

Due to POST PARTUM LEUKEMIA

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. DeLand M. D.
Address 1200 N. Caroline St. Date signed 10-7-45

VS 180

G33005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balt - 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 Gwynn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Baby Spelsberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 - 45

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

9. Birthplace Balt - Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Dr. Walter Spelsberg
13. Birthplace Clarksberg, W. Va -

MOTHER 14. Maiden Name Martha Tonkin -
15. Birthplace Clarksburg, W. Va -

16 (a) Informant Father
(b) Address 335 Gwynn Ave - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)
(c) Cemetery or crematory Cash Val
Location Baltimore Md

18 (a) Funeral director Wm A Stanley
(b) Address Fulton & Fayette

19 (a) Date filed OCT 8 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

11:59 AM

20. DATE OF DEATH 10/5 1945, at [redacted] M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 5 1945, and that I last saw her alive on Oct 5 1945.

Immediate cause of death	Duration
Respiratory failure -	
Cardiac failure -	
Due to Prematurity (6 mos)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William N. Osborne M.D.
Address Mercy hosp. Date signed Oct 9, 45

G33006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33006

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Miller St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Miller St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ophelia Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1909

8. AGE: Years	Months	Days	If less than one day
36	4	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Reed
13. Birthplace Va

MOTHER
14. Maiden Name Eliza Pleasant
15. Birthplace Va.

16 (a) Informant Lula Stanley
(b) Address 1629 Miller St.

17 (a) Burial (b) Date thereof Oct 8 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A A County Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1129 N Caroline St.

19 (a) Oct 8 1945 Huntington Williams
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945, at 4:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1945 to Oct 4 1945, and that I last saw h alive on Oct 4 1945

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Myocardial Degeneration

Due to Chronic Nephritis Cystitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Lefferd M. D.

Address 822 N. Bond St Date signed 10/9/45

1945
73
G33007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

73 B

Registered No. G33007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Southview Road
(c) Hospital or institution: Northwood
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Southview Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard H. Hanlon

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-6977

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Harriet R. Hanlon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3. 1875

8. AGE: Years 70 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Commercial Salesman

11. Industry or business Men's Hats

FATHER
12. Name Bernard Hanlon
13. Birthplace Ireland

MOTHER
14. Maiden Name Rose Hanlon
15. Birthplace Ireland

16 (a) Informant Mrs. Hanlon
(b) Address 1210 Southview Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) OCT 8 1945 (Date rec'd by registrar) (b) Dr. [illegible] Physician for [illegible], M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1945 to Oct 5 1945, and that I last saw h[illegible] alive on Oct 5 1945.

Immediate cause of death: Thrombosis of Left Middle Cerebral Artery — Duration 5 day

Due to: Arteriosclerosis

Due to: Cerebral & General — Duration 10 yrs. (?)

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R. Doughty M.D.
Address 12 E Bradle St Date signed Oct 5, 1945

X GERAGHTY

G33008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

43D

Registered No. G33008

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw & Wilkens Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2302 Mosher St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernadine E. Bell

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband Harry L. Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25th 1884

8. AGE: Years	Months	Days	If less than one day
61	2	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Anthony J. Hummel

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Dena Musman

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Milbert J. McKitrick

(b) Address 2302 Mosher Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 10th 1945 (month) (day) (year)

(c) Cemetery or ~~Crematory~~ New Cathedral

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.

(b) Address North & Penna Aves.

OCT 8 - 1945 Date rec'd by registrar — for Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945 at 3:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945 to 10/7 1945 and that I last saw her alive on 10/7 1945

Immediate cause of death	Duration
Cerebral Embolism	
Due to arterio sclerosis	
C-V-D.	
Due to	
Other Conditions. Embolism C	
left leg.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Cliff Parrott, M.D.

Address St. Agnes Hosp Date signed 10/11/45

VS 150

G33009 ✓ G33009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 Tunbridge Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jared T. Owens

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha E. (Kinsey) Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frank V. Owens
13. Birthplace Ireland

MOTHER
14. Maiden Name Ida Von Walter
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bertha E. Owens
(b) Address 109 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 8 - 1945 (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1945, at 2204 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 10-7 1945.
and that I last saw him alive on 10-6 1945.

Immediate cause of death	Pulmonary edema	
Due to	Congestive heart failure	
Due to	Prostatectomy for BPH	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 10-2-45
Major findings of operation: B.P.H.
of autopsy: above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 0 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley R. Steinbach M. D.
Address Sinai Hospital Date signed 10-7-45

VS 150

G33010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33010 163H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Henry List

3 (b) If veteran, name war none

3 (c) Social Security Account No. 214-01-9450

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thirza List

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1908

8. AGE:

Years	Months	Days	If less than one day
36	9	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business

FATHER
12. Name John P. List
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ella Virginia Finch
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thirza List
(b) Address 1831 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 45 19, at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Fell mounting Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-6-45 at 4 P. M.
(b) Where did injury occur? 1831 N. Fulton Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Kitchen gas range, under burners

23. Signature Howard J. Mileski M.D. Medical Examiner.
Date signed October 7, 1945.

VS 151

G33011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G33011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH M. VORDEMBERGE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Vordemberge
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Niemann
15. Birthplace Germany

16 (a) Informant Mr. Clarence Pierson
(b) Address 5002 Parkton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 8 - 1945 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1945 to Oct 5 1945, and that I last saw h er alive on Oct 4 1945.

Immediate cause of death	Duration
Cardiac Failure Collapse	12 hrs.
Due to general Carcinomatosis -	4 - 5 yrs.
Due to Carcinoma began in left breast which was removed	
Other Conditions 8-44-290 -	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. C. Bowman Hood M. D.
Address 2200 Garrison Blvd Date signed 10-6-45

VS 150

G33012

JL - 96479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G33012 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-9034

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1890

8. AGE: Years	Months	Days	If less than one day
55	?	?	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name George Smith
13. Birthplace Virginia

MOTHER 14. Maiden Name Ella
15. Birthplace Virginia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

OCT 8 - 1945
(Date rec'd by registrar)

(a) (b) Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1945 19 , at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4, 1945 to Oct. 5 1945, and that I last saw him alive on Oct. 5 1945

Immediate cause of death	Duration
Cerebral hemorrhage, site unknown	
Due to Arteriosclerosis and hypertension	
Other conditions: Bronchopneumonia	
cardiac hypertrophy	
Other Conditions Coronary arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy as above (incomplete)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Haddaway M. D.
Address B C H Date signed 10/7/45

VS 150

TO BE APPROVED BY MEDICAL EXAMINER Howard J. Haddaway, M.D. 83a

G33013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33013
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2000 Race St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 E. Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dennis Alessi

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4-1884

8. AGE: Years	Months	Days	If less than one day
60	10	1	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business

FATHER 12. Name Vincent Alessi
13. Birthplace Italy

MOTHER 14. Maiden Name Mary Maggio
15. Birthplace Italy

16 (a) Informant Dr. Silvio Alessi
(b) Address 6217 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Cusack
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntingtown, Williamsport, Md.

OCT 8 - 1945

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1945, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 5 1945 and that I last saw h alive on 19

Immediate cause of death Coronary thrombosis

Due to arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Duration: 7 hrs

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 16 Randall Date signed

X

633014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

633014

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Berwick Ave
(c) Hospital or institution Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Berwick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney ~~Gilbert~~ R. ~~Miller~~ Raymond Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8. 1889

8. AGE: Years	Months	Days	If less than one day
56	3	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Steamen

11. Industry or business Jewel Tea Co

FATHER
12. Name John Miller
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Schaffer
15. Birthplace Md.

16 (a) Informant Anna Marie Miller
(b) Address 2905 Berwick Ave.

17 (a) Burial (b) Date thereof 10-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director L. J. Rucks
(b) Address 5305 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945, at 6 35 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1945, to 10/7 1945, and that I last saw him alive on 10/7 1945

Duration

Immediate cause of death Uremia

Due to Tuberculosis kidney

Due to Benign Essential Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Chastain M. D.
Address Date signed

Dr. James Cavanaugh
3326 Mc Elderry St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Md Elderry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Mc Elderry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Greenwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife L. Henrietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1878

8. AGE: Years	Months	Days	If less than one day
67	5	--	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Grand Rapids, Co.

FATHER
12. Name Walter Greenwood
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Lee
15. Birthplace Maryland

16 (a) Informant Mr. William E. Greenwood
(b) Address 6109 Sefton Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

19 (a) (Entered by registrar) (b) Registrar

OCT 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th, 1945, at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1942 to 10-5 1945, and that I last saw him alive on Oct 5 1945.

Immediate cause of death CORONARY THROMBOSIS — Duration 10 DAYS
ANGINA PECTORIS — 2 YRS
Due to HYPERTENSION — 2 YRS
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kavanaugh M.D.
Address 3328 Mc Elderry St Date signed 10-5-45

Huntington Williams, M.D.

G33016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G33016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4011 PARKSIDE DRIVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4011 PARKSIDE DRIVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK F. WIENERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY WIENERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 30 1881

8. AGE: Years	Months	Days	If less than one day
64	3	4	hr. min.

9. Birthplace BALTIMORE MD? (Town, county, and state)
10. Usual Occupation PRINTER
11. Industry or business

FATHER
12. Name WILLIAM WIENERS
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA OHELES
15. Birthplace GERMANY

16 (a) Informant MARY WIENERS (WIFE)
(b) Address 4011 PARKSIDE DRIVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 9/45 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) [illegible] registrar Huntington Williams, M.D.

OCT 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 4 19 45 at 11/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Oct 4 1945.
and that I last saw h/ alive on Oct. 3 1945.

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to Arterio-Sclerosis
Due to Chronic Myocarditis
Due to Chronic Nephritis
Other Conditions Cardiac Asthma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Judeson M. D.
Address 3001 Sherwood Drive Date signed Oct. 6-45

X

633017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633017

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. --------
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Frank M. Bond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mabel Hann

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) April 3, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	4	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired court clerk

11. Industry or business --------

FATHER
12. Name James Bond
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Lyon
15. Birthplace Baltimore, Maryland

16 (a) Informant Thomas Bond
(b) Address 524 Orkney Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert Street

19 (a) (Date received) OCT 8 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 10/8/45

G33018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 245 N. Carey St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Anna Melcher (adopted)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15th 1877

8. AGE: Years	Months	Days	If less than one day
68	2	21	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Connell
15. Birthplace ?

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (Date received by registrar) OCT 8 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6th 1945, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5th, 1945, to Oct 6 1945, and that I last saw her alive on Oct 5, 1945.

Immediate cause of death	Duration
arteriosclerotic cardiovascular disease	
Due to	
Due to	
Other Conditions Psoriasis	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent de P. Fitzpatrick Jr. M.D.
Address Mercy Hospital Date signed 6/6/46

Supplemental: John R. Davis M.D. per Robert Lee Gutman M.D.

G33019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G33019

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St + Lafayette Ave
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Hilton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Katherine Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married.

6 (b) Name of husband or wife Basil A. Griffith
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Homemaker
11. Industry or business

FATHER
12. Name Phillip Hazel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Appolonia Schuring.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Griffith
(b) Address 204 N Hilton St.

17 (a) Burial (b) Date thereof 10-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon P.K. Com
Location Frederick Ave.

18 (a) Funeral director Harry A. Witzke
(b) Address Hollins & Gilmor St.

19 (a) (b)
(Signature of local registrar)

OCT 8 1945
VS 150

Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945, at 2.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945, to Oct 7 1945, and that I last saw h[er] alive on Oct 7 1945.

Immediate cause of death
Generalized Carcinomatosis Ascites
Due to Intestinal Malignancy (?).
Due to
Other Conditions Anemia
(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation:
of autopsy: None.

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Allen Deckert
Address 1127 St Paul St Date signed 10/7/45 M. D.

X

G330,60

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G330,60

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 yrs 7 mo 26 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Gabriel Bannon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary A. Bannon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1868

8. AGE: Years	Months	Days	If less than one day
77	6	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Patrick Bannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie McCallister
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 old Frederick Rd.

18 (a) Funeral director Harry N. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Williams, Md. Registrar

OCT 9 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945, at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1934 to Oct 6 1945, and that I last saw h.i.m. alive on Oct 6 1945.

Immediate cause of death Carcinoma of the esophagus — Duration 8 mo

Due to

Due to

Other Conditions Bronchopneumonia — 8 yrs 7 mo 26 da

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas P. Blagg M.D.
Address 336 Cathedral St (Date signed)

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 939 633064

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State M (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Aisquith St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. John C. Gary

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-6886

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ada Gebhardt

6 (c) If married, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1879

8. AGE: Years 66 | Months 7 2 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Am. Bus. Co.

FATHER 12. Name John Gary

13. Birthplace Germany

MOTHER 14. Maiden Name Mary [illegible]

15. Birthplace Germany

16 (a) Informant Wife

(b) Address 615 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn Md

18 (a) Funeral director Harry A. Wilke

(b) Address 401 Edmondson

19 (a) (Date received by registrar) (b) Registrar

Huntington Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1945 at 7:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1945 to 10/6 1945. and that I last saw h[illegible] alive on 10/6 1945.

Immediate cause of death Cardiac failure

Due to Arteriosclerosis

Due to Cardio-vasc disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clift Ratcliff Jr. M. D.

Address St Agnes Hosp Date signed 10/6/45

(over)

VS 150

G33022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G33022 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Kimble Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Merryman Albert M. Talbott Talbott

3 (b) If veteran, name war Spanish-American

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Talbott

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1886

8. AGE: Years	Months	Days	If less than one day
59	1	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Ship Yard

FATHER
12. Name William Fillmore Talbott,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Creamer,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Talbott,
(b) Address 3900 Kimble Rd.

17 (a) Burial (b) Date thereof 10/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 45 19, at 9:05 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease.

Due to

Other Conditions Pulmonary edema, chronic nephritis, Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed October 7, 1945.

G33023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33023
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Withers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7 1945

8. AGE: Years	Months	Days	If less than one day
			10 hr. 20 min.

9. Birthplace W. B. D. H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Warren Withers
13. Birthplace Altoona, Pa

MOTHER
14. Maiden Name Melrose Burdell
15. Birthplace Pitts. Pa

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 8 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 8 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1945 at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 19 45 to 9/7 19 45
and that I last saw h[illegible] alive on 9/7 19 45

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Silberfeld
Address W. of Balt Gen Hosp Date signed 19 45 10 5

VS 150

2997

G33024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G33024

Registered No.

HB 68632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3 6 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Haywood Ave. (If rural give location) Haywood
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Hood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clayton J. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1921.

8. AGE: Years	Months	Days	If less than one day
24	6	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W Switzer(d)
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth M. Abrams
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave. Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Lasing Parsons
(b) Address 5005 Park Heights Ave

19 (a) (b) Huntington Williams, M.D. Registrar
OCT 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 19 45 at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21, 1944 to Oct. 6 1945. and that I last saw her alive on Oct. 6, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Tuberculous Enteritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B Copeland Jr M.D.
Address Balto. City Hosp. Date signed 10/6/45

G33025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G33025 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2133 Forest Park Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2133 Forest Park Ave., (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Matilda Durding

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William R. Durding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1891

8. AGE: Years	Months	Days	If less than one day
53	11	27	hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER

12. Name Robert L. Tucker

13. Birthplace Howard Co., Md.

MOTHER

14. Maiden Name Elizabeth E. Hobbs

15. Birthplace Howard Co., Md.

16 (a) Informant Mr. William R. Durding

(b) Address 2133 Forest Park Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd

Location Howard Co., Md.

18 (a) Funeral director G. Howard Strong

(b) Address 3207 W. North Ave., Huntington Williams, Mgr.

19 (a) (Date received by registrar) Registrar

OCT 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1945, at 3.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1945 to Oct 7, 1945 and that I last saw her alive on Oct. 7, 1945

Immediate cause of death — Duration

Cerebral Hemorrhage — 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature

Address 2757 W. Lan. Date signed 10/8/45

633026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 633026

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 Poplar Hill Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Poplar Hill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Howard Millikin

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-16-6006

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Pauline von Maries

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 10 1871

8. AGE: Years	Months	Days	If less than one day
73	10	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Pres. Hennegen & Bates

11. Industry or business Jewelers

FATHER
12. Name Wm H. Millikin
13. Birthplace Md

MOTHER
14. Maiden Name Emily V. Richardson
15. Birthplace Md.

16 (a) Informant Miss Jane Millikin
(b) Address 700 Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Henry W Jenkins Sons Co
(b) Address N Gilmor & Orchard Sts.

19 (a) 1945 (b)
(Date received by registrar) Huntington Hillsville, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to Oct 6 1945 and that I last saw him alive on Oct 6 1945

Immediate cause of death Coronary Occlusion — Duration 10 min

Due to Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Levine M. D.

Address 4302 Eldorado Ave Date signed Oct 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 120889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Hughesville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dallis Goldsmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary Carter Goldsmith

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years	Months	Days	If less than one day hr.	min.
39				

9. Birthplace Charles Co Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name Abraham Goldsmith

13. Birthplace Chas. County Md

MOTHER 14. ~~Maiden~~ Name Ida Goldsmith

15. Birthplace Chas County Md

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)

(c) Cemetery or crematory Old Fields

Location Highgate Md

18 (a) Funeral director Elmer Gilbrook

(b) Address Hughesville Md

19 (a) 10-6-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1945, at 6 44 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1945 to 10/8 1945, and that I last saw him alive on 10/8 1945.

Immediate cause of death Cardiac failure — Duration

Due to Hemochromatosis

Due to

Other Conditions Diabetes Cirrhosis of liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Grey M. D.

Address Date signed

VS 150

G33028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

Registered No. G33028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Carbett near Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Clinton Govens

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	married

6 (b) Name of husband or wife Clara Govens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1885

8. AGE: Years	Months	Days	If less than one day
60	—	—	hr. min.

9. Birthplace White Hall Md (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business Farm

FATHER
12. Name John Govens
13. Birthplace Balto Co Md

MOTHER
14. Maiden Name Georgie Berry
15. Birthplace Balto Co Md

16 (a) Informant Clarence Govens
(b) Address Rockdale Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 16-45 (month) (day) (year)
(c) Cemetery or crematory St James cem
Location Federal Hill Harford Co Md

18 (a) Funeral director Martin Kurtz
(b) Address Jarrettsville Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1945, at 11 38 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1945 to 10-7 1945 and that I last saw him alive on 10-7 1945.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio-Vascular-Renal Disease	
Due to	
Other Conditions Carcinoma of Liver Site of origin unknown (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reece R. Boone, Jr. M. D.
Address University Hosp. Date signed 10-8-45

VS 150

6330 29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 6330 29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Allendale Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Allendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simon Schuchat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Finance Bussiness

FATHER
12. Name David Schuchat
13. Birthplace Russia

MOTHER
14. Maiden Name Tema Schuchat
15. Birthplace Russia

16 (a) Informant Mrs Sarah Schuchat
(b) Address 2910 Allendale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 9/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cemetery
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 9 - 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 9.04

20. DATE OF DEATH October 7 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Oct 7 1945, and that I last saw him alive on Oct 7 1945.

Immediate cause of death	Duration
Exhaustion	3 day
Due to Carcinoma of Stomach	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Goldstone

Address 1113 Linden Av. Date signed Oct. 8, 1945

VS 150

633030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

Registered No. 633030

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Harford Rd. & Herring Run.

(c) Hospital or institution Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Howard

(c) City or town Elkridge

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1954 Railroad Ave.

(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Francis Stallings

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22nd 1939

8. AGE: Years	Months	Days	If less than one day
6	4	15.	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER 12. Name Charles W. Stallings

13. Birthplace Baltimore

MOTHER 14. Maiden Name Edith Ryan

15. Birthplace Baltimore

16 (a) Informant Mr. Charles W. Stallings

(b) Address 1954 Railroad Ave. Elkridge

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)

(c) Cemetery or crematory Locust Park Cemetery

Location 3801 Frederick Ave.

18 (a) Funeral director John J. Cowan & Son

(b) Address 901-03 W. Pratt St.

OCT 9-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1945, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-7 1945 and that I last saw him alive on 10-7 1945

Immediate cause of death	Duration
Poliomyelitis, bulbo-spinal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Melchijah Spragins, M.D.

Address H. H. Sydenham Date signed 10-9-45

V8 8

PRINT WITH PENCIL, WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 633031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 W Ostend St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 W Ostend St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T. Baker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1875

8. AGE: Years 70 Months 2 Days 28 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation stock clerk

11. Industry or business John Duer Co.

FATHER 12. Name Geo Baker

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Hillen

MOTHER 15. Birthplace Unknown

16 (a) Informant Mrs. Matilda Baker

(b) Address 1101 W Ostend St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location 3801 Frederick Ave.

18 (a) Funeral director John Conway Son

(b) Address 901-03 W Lafayette Ave

19 OCT 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1945 at 4:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-6 1945. and that I last saw h alive on 10-6 1945.

Duration
Immediate cause of death Coronary Thrombosis	1 hr
Due to Coronary Disease	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph H Lautenbach M. D.

Address 1101 W Ostend St Date signed 10/8/45

VS 150

633032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942

Registered No. 633032

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Albert Jaeger

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1886

8. AGE: Years 59 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name Anthony Jaeger
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Napkel
15. Birthplace Balto. Md.

16 (a) Informant Mr Peter Stankewitz
(b) Address 122 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem
Location 5608 Edgewood Road

18 (a) Funeral director Todd J. Howard & Son
(b) Address 901-03 Hollins St.

19 (a) 10-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1945, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1945 to 10-7 1945 and that I last saw her alive on 10-7 1945.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C Hayden M.D.
Address Bon Secours Date signed 10-7-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G33033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33033

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St.

(c) Hospital or institution: President Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 426 N. Calhoun St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1945

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baily md. (town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Wayland Jones

13. Birthplace N. C.

MOTHER

14. Maiden Name Peggy Butler

15. Birthplace N.C.

16 (a) Informant Peggy Jones

(b) Address 426 N. Calhoun St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore, Md.

18 (a) Funeral director Chas. Luigi N. Wiland

(b) Address 1681 Druid Hill Ave

(a) Date rec'd OCT 9 - 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 7 1945, at 6 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 2 1945, to 10 - 7 1945, and that I last saw her alive on 10 - 7 1945.

Immediate cause of death	Duration
prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place.)

(e) Means of injury

23. Signature W. W. Butler M. D.

Address 1033 Druid Hill Ave Date signed 10/8/45

G33034 480564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 L

Registered No. G33034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Quille

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-95

8. AGE: Years	Months	Days	If less than one day
50	6	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Monroe Yate
13. Birthplace Md

MOTHER
14. Maiden Name Susan Henae
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 11 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md

18 (a) Funeral director Wm. H. Haslam
(b) Address 1631 Druid Hill Ave

19 OCT 9 - 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1945, at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1945 to Oct. 8 1945, and that I last saw her alive on Oct. 8 1945.

Immediate cause of death Renal failure — Duration
Due to Cardiac and Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Sept 29, 1945
Major findings of operation Carcinoma of Head of Pancreas
or autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. A. Cooley M.D.
Address 720 J. Hopkins Hosp. Date signed 10-8-45

VS 150

G33035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G33035 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2341 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wooding

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widowed

6 (b) Name of husband or wife William Wooding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1882

8. AGE: Years	Months	Days	If less than one day
63	8		hr min.

9. Birthplace Gloucester Co Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Thomas Robinson
13. Birthplace Gloucester Co Va
14. Maiden Name Eliza Stubbs
15. Birthplace Gloucester Co Va.

16 (a) Informant Leon E. Wright
(b) Address 2341 Druid Hill Ave

17 (a) Burial (b) Date thereof Oct. 11, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laud. A. Hoffman
(b) Address 1651 Druid Hill Ave

19 OCT 9 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1945, at 11.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1945, to Oct 6 1945, and that I last saw h-r alive on Oct 6 1945.

Immediate cause of death	Duration
Hypertensive Cardio-Vascular disease.	
Due to	
Due to	
Other Conditions Nephritis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald B. Lightston M. D.
Address 501 Cherry Hill Rd. Date signed 10/8/45

633036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

633036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address Lakeland + 33rd

(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4738 Old York Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ELLA FRANCIS THOMAS

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8. 1870

8. AGE: Years 75 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Kitchen Worker

11. Industry or business Private Family

FATHER 12. Name Joseph Thomas

13. Birthplace Va.

MOTHER 14. Maiden Name Mary E Smith

15. Birthplace Anne Arundel Co Md

16 (a) Informant Esther V. Rushworth

(b) Address 533 Longwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location: Baltimore Md

18 (a) Funeral director William Cook Inc

(b) Address 1312 Park Ave

19 (Date rec'd by registrar) OCT 9 - 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/45 19 , at 1:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John C Davis M.D. Medical Examiner.

Date signed 10/8/45

VS 151

6333037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 6333037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & John St.

(c) Hospital or institution: Hospital for Women of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs 7 mos 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 938 Homestead St (If rural give location)

(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Emma Blanche Stagmer

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jesse B Stagmer

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) 3/2/1873

8. AGE: Years 72 Months 7 Days 4 6 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James V. Pryor

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Anna M Lock

15. Birthplace Baltimore Md

16 (a) Informant Jesse B Stagmer

(b) Address 938 Homestead St

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore Md

18 (a) Funeral director Wilson Co Inc

(b) Address 2104 Pont St

19 (a) Filed OCT 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1945, at 2:03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1945 to 10/8 1945, and that I last saw her alive on 10/8 1945.

Immediate cause of death: Respiratory failure, Hypertension

Due to Diabetic Coma

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 days wk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Richard Compton M. D.

Address Hospital for Women Date signed 10/8/45

G330338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838 Registered No. G330338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Sargeant St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Sargeant St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie A Wirth

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Edward A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	1	hr. min.

9. Birthplace Harrisburg Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant David L Wirth
(b) Address 1226 Sargeant St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Wilhelm Eichler
(b) Address 319 N Paca St
19 (a) OCT 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1945, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1944 to Oct 6, 1945, and that I last saw h[illegible] alive on Oct 6, 1945.

Immediate cause of death	Duration
Acute Heart Failure	1 day
Due to Cerebral Thrombo	
Due to Arteriosclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J Klein M. D.
Address 726 Overlea Blvd Date signed 10-8-45

X

G33039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G33039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MISTAKES RESULTING FROM ERASURES MUST BE PAID FOR BY BEARING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 3 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 E. Gittings St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME RUTH E. GRAHAM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife CHAS. A GRAHAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 31, 1900

8. AGE: Years	Months	Days	If less than one day
45	10	8	hr. min.

9. Birthplace MASS. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name WILLIAM HARDING
13. Birthplace MASS.

MOTHER
14. Maiden Name ALICE DOLAN
15. Birthplace MASS.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem
Location Taylor Ave

18 (a) Funeral director John C Melly Sons
(b) Address 2435 E Oliver St

19 (a) (Signature of local registrar) (b) Registrar

OCT 9 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1945, to Oct 8 1945, and that I last saw her alive on Oct 8 1945.

Immediate cause of death	Duration
Malnutrition & Dehydration	
Due to Generalized Carcinomatosis.	1 Year.
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Wheeler, M.D.
Address South Balto. Gen. Date signed 10/8/45

G330-0 Lohnes ✓ G330-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 E Preston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Lohnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ella Mae Lohnes

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 4 1874

8. AGE: Years 71 | Months 5 | Days 2 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Fire Dept.

FATHER
12. Name Wendell Lohnes
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Eisenrodt
15. Birthplace Germany

16 (a) Informant Ella Mae Lohnes
(b) Address 2318 E Preston St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem Park
Location Taylor Ave.

18 (a) Funeral director John F Milly Son
(b) Address 2435 E Oliver St

19 (a) OCT 9 — 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Octber 3 1945 to Octber 6 1945 and that I last saw h[illegible] alive on Octber 6 1945.

Immediate cause of death: Coronary Occlusion — Duration: 1 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Spindler M. D.
Address 1621 E Fayette St Date signed 10-8-1945

VS 150

G33041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 N. Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Virgie Brooks.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 27 1890

8. AGE: Years 55 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Lee Andrew Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Mary Beckett
15. Birthplace Md

16 (a) Informant Virgie Brooks
(b) Address 324 N. Gilmor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-'45 (month) (day) (year)

(c) Cemetery or crematory Arbury
Location Balto. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Pennsylvania Ave

19 (a) OCT 9 1945 (Date rec'd by Registrar) (b) Lemuel Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1945 5:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Mar 14 1945 to Oct 4 1945.
and that I last saw him alive on Oct 4 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to 2nd Stroke 1 year	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. C. Link M. D.
Address North Ave & Division Date signed

G33042 ✓ G33042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Harlene Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marie Carey

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife Millard Carey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	11	hr. min.

9. Birthplace Ellicott City, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Addison
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Healy
15. Birthplace Howard Co. Md.

16 (a) Informant Joseph M. Carey
(b) Address Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Stone
(b) Address Ellicott City, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 9 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945 at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1945 to 10/7 1945 and that I last saw her alive on 10/2 1945

Immediate cause of death Cardiac failure — Duration
Due to Artery sclerosis Cardiac Renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifford Perrott M.D.
Address St. Agnes Hosp Date signed 10/9/45

G33043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G33043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 Bloomsberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (3a) (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Bloomsberry (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Katie (Catherine E.) Hartline

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martin J. Hartline (Deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1883

8. AGE: Years 62 | Months — | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

FATHER 12. Name John Niemeyer

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Louise (?)

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mildred Connally (Daughter)

(b) Address 3607 West Bay Ave., Balto. 25, Md.

17 (a) Burial — (b) Date thereof Oct 10 1945 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Cedar Hill Cem.

Location R. R. Co., Md.

18 (a) Funeral director Gilbert Howard Evans

(b) Address 1400 S. Charles St., Balto. 30, Md.

19 OCT 9 - 1945 (Date rec'd by local reg.) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1945, at 1:15 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1945 to Oct 7 1945, and that I last saw her alive on Oct 7 1945

Immediate cause of death: Coronary thrombosis — Duration 3 hours

Due to: arteriosclerosis

Due to: —

Other Conditions: arthritis — 6 mos

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Isaac Muller M. D.

Address 125 N. Charles St. Date signed Oct 10 1945

VS 190

63044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

Registered No. 63044

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 S. Robinson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 S. Robinson Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Stella M. Leader

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John M. Leader
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1888

8. AGE: Years	Months	Days	If less than one day
56	10	5	hr. min.

9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Not known " "
13. Birthplace

MOTHER
14. Maiden Name Not known " "
15. Birthplace

16 (a) Informant Husband
(b) Address 1114 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

OCT 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1945 to Oct 7 1945, and that I last saw h[illegible] alive on Oct 6 1945.

Immediate cause of death	Duration
Chr. Thyrotoxicosis	1-2-45
Neoplasm Liver C.V. Disease	1-2-45
Due to Congestive Failure	Oct 5/45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Schumacher M. D.
Address 842 S. Conkling Date signed 10-8-45

VS 150

045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. 633045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3210 B everly Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 B everly Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Krauk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	White	Widow

6 (b) Name of husband or wife George Krauk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24, 1872

8. AGE: Years	Months	Days	If less than one day
73	6	12	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Alexander Millar
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Irons
15. Birthplace Ireland

16 (a) Informant Anna Krauk
(b) Address 3210 Beverly Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell Street

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) OCT 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1945 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to Oct. 6 1945 and that I last saw her alive on Oct. 6, 1945.

Immediate cause of death	Duration
Carcinoma of Uterus.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D. M. D.
Address 2739 Eastern Ave Date signed 10/8/45.

633046

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

633046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3529 Elliott St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia D. Strobel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	W	W

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1866

8. AGE: Years	Months	Days	If less than one day
79	2	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Graper
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mrs. Marie Smit
(b) Address 3529 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) OCT 9 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1945, at 7 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Oct 4 1945 and that I last saw h[illegible] alive on Oct 4 1945.

Immediate cause of death Hypertension Arteriosclerotic H. Disease. Gangrene of left foot.
Due to Suppurative fracture

Duration
Sept 10/45
Sept 29/45

Due to
Other Conditions None.
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. Schumack M. D.
Address 842 S. Exeter Date signed 10-6-45

VS 150

G33047 ✓ G33047

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 122B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto.
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS L. CRAFTON JR.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1945

8. AGE: Years | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Balto. Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas L. Crafton Sr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ruth Hoffenbuyer
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Ruth H. Crafton
(b) Address 404 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore County
Location East of E. North Ave.

18 (a) Funeral director Edward W. Coughlin Sons
(b) Address 924 E. Eager St.

19 (a) (Name of registrar) (b) Registrar

Oct 9 1945
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 19 45 at 1 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 19 45 to Oct 7 19 45, and that I last saw h[illegible] alive on Oct 7, 19 45.

Immediate cause of death — Duration
Cardio-respiratory failure
Due to Toxaemia & dehydration
Due to Bronchopneumonia & intestinal obstruction - partial
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Lung congestion mechanical obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1400 N Caroline St Date signed 10/7/45

G33048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

G33048 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles S. Feeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1945

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph A. Feeney
FATHER 13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary A. Venturella
MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Joseph A. Feeney
(b) Address 11 [illegible] Williams St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Brooklyn Md. Balto. Md.

18 (a) Funeral director E. Harle Inc.
(b) Address 115 E. West St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 9 1945 Huntington Williams, M.D.

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1945, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1945 to 10/8 1945
and that I last saw h[illegible] alive on 10/8 1945

Immediate cause of death	Duration
Dehydration	
Due to Diarrhea (Infection)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel

Address Md. Gen. Hospital Date signed 10/8/45 M. D.

X

G33049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33049

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1552 N. Bruce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George White

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race COLORED | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1889

8. AGE: Years 56 | Months 4 | Days - | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Annie Monroe

(b) Address 1552 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Thomas E Felson

(b) Address 1303 Presstman Street

OCT 9 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945, at 7.05 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNally M.D. Medical Examiner.

Date signed 10/8/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633050

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46B 633050 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N.GLOVER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N.GLOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: CHARLES CARROLL RIVERS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANNA M.THOMPSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.4 1881

8. AGE: Years 64 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation STA.ENGINEER

11. Industry or business LORD BALTO.LAUNDRY

FATHER
12. Name CHARLES C.RIVERS
13. Birthplace MAINE

MOTHER
14. Maiden Name ROXYALINA MILLER
15. Birthplace MAIN

16 (a) Informant ANNA M.RIVERS (WIFE)
(b) Address 228 NORTH GLOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT.10/45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK ROAD

18 (a) Funeral director Lilly & Zeilenga
(b) 1406 S. WOLFE ST.

19 (a) (b) Registrar
(Date rec'd by registrar) OCT 9 - 1945
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT.6 1945 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6, 1945 to Oct 6 1945, and that I last saw h[illegible] alive on Oct 6, 1945.

Immediate cause of death: Intestinal Obstruction — Duration 3 days.
Due to Ca - stomach —
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Kleiner M. D.
Address 2623 E. Monument Date signed 10/8/45

For J.R. Davis, by Howard J. Kleinfeldt, M.D.

VS 150

G33051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

484

Registered No. G33051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 45 Henrietta St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 45 Henrietta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie W. Rowles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Westley W. Rowles
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 12-1-1870

8. AGE: Years	Months	Days	If less than one day
74	10	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name ? Daniels
13. Birthplace North Carolina

MOTHER
14. Maiden Name ? Potter
15. Birthplace North Carolina

16 (a) Informant Mr Zach W. Rowles
(b) Address 2529 Lauretta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edmondson Ave

16 (a) Funeral director John T. Wm. Sons, Inc. b.d. Lees
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7th 1945, at 10:05 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 7 1945 and that I last saw he alive on 10-7-1945

Immediate cause of death Carcinoma of Cervix - (Marked emaciation)

Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. S. Fowble M. D.
Address 642 Wash. Blvd. Date signed 10-8-45.

VS 150 OCT 9 - 1945 Huntington Williams, M.D.

G33052

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G33052 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5402 Cedella Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5402 Cedella Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH LOUISE DISNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William J. Disney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 73 | Months | Days | If less than one day: hr. min.

9. Birthplace A. A. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William J. Disney
13. Birthplace Md.

MOTHER
14. Maiden Name - Downs
15. Birthplace Md.

16 (a) Informant Mr. William J. Disney
(b) Address 5402 Cedella Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.
OCT 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1945, at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Oct 6 1945, and that I last saw h[illegible] alive on Oct 6 1945.

Immediate cause of death Pulmonary Congestion & Pneumonia — Duration

Due to Pneumonia

Due to — over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Perry Carman, M. D.
Address 1701 N. Carolina Date signed Oct

G33053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3913 Chatham Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3913 Chatham Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J. O'BRIEN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Moulton O'Brien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1866

8. AGE: Years 79 | Months 7 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William J. O'Brien

FATHER 13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Kate McCarthy

MOTHER 15. Birthplace Washington, D. C.

16 (a) Informant Mr. Seymour O'Brien

(b) Address 3943 Canterbury Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)
(Date received by registrar) Registrar

OCT 9 1945 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1945, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940, to 10-8-1945, and that I last saw him alive on 10-9-1945.

Immediate cause of death	Duration
Congestive heart failure	1 hour
Due to Arterio Sclerotic heart	5 yrs
Due to disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Howard H. Warner M. D.

Address 2004 Larman Ave Date signed 10-9-45

(G33054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

Registered No. G33054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Pulaski Hwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Pulaski Hwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Lee Hardesty

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-03-2826

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Hardesty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1878

8. AGE: Years 67 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace Prince George Co. Md.
(Town, county, and state)

10. Usual Occupation Insurance agent

11. Industry or business (Retired)

FATHER
12. Name Francis Hardesty
13. Birthplace Md.

MOTHER
14. Maiden Name Susa Skinner
15. Birthplace Md.

16 (a) Informant Mrs. Margaret Hardesty
(b) Address 3017 Pulaski Hwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 11 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eastern Ave

(a) (b)

OCT 9 - 1945
(Date rec'd by registrar)

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945 at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to Oct. 8 1945 and that I last saw h— alive on Oct. 8 1945.

Immediate cause of death Bronchopneumonia

Due to Labral Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 days
8 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Herwig Sons
Address 2442 E. Fayette St. Date signed 10/8/45

VS 150

G33055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G33055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3257 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Dora White

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Charles White
6 (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Sept 10, 1876

8. AGE: Years	Months	Days	If less than one day
69	-	28	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Charles White
(b) Address 3257 Chestnut Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location

18 (a) Funeral director Edmonds & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DCT 9 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1945, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1945 to 10/8 1945, and that I last saw her alive on 10/8 1945.

Immediate cause of death Cardiac failure — Duration

Due to Coronary insufficiency

Due to Atherosclerotic Cardiovascular disease.

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dorothy T. Evans M. D.
Address Franklin Square Hosp. Date signed 10-9-45

925

G33056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600a

G33056

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fulton + Catonsville Ave

(c) Hospital or Institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore - 11 (If outside city or town limits, write RURAL and give town)

(d) Street No. 3426 Keswick Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Bounds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-45

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Robert C. Bounds Jr.

13. Birthplace Md.

MOTHER 14. Maiden Name Helen Baldwin

15. Birthplace Md.

16 (a) Informant Christina M. Baldwin

(b) Address 3426 Keswick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/45 (month) (day) (year)

(c) Cemetery or crematory St. Marys

Location Govanstown

18 (a) Funeral director Edmondson & Donovan

(b) Address 3615-11 Edmondson Ave

19 (a) OCT 9 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1945 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1945 to 10-8 1945 and that I last saw him alive on 10-8 1945

Immediate cause of death Intracranial Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Howard Kernohan

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. R. DeElear Jr.

Address St Agnes Hosp Date signed 10/9/45

X

G33037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (30)

G33057

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Pennsylvania Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Pennsylvania
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Arthur Brewer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1904

8. AGE: Years	Months	Days	If less than one day
41	6	-	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Barber
11. Industry or business Business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Maggie "
15. Birthplace North Carolina

16 (a) Informant Virginia Brewer
(b) Address 11 Or. Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 8 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS Form OCT 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th 1945, at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Syphilitic Aortitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gutsen M.D.
Medical Examiner.
Date signed Oct.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N. Monford.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sandler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Casper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1875

8. AGE: Years	Months	Days	If less than one day
70	3 4	5	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Weimann
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara
15. Birthplace Germany

16 (a) Informant Casper Sandler
(b) Address 422 N. Montford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-11-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director John J. Moran
(b) Address 3600 E. Balto. St.

19 (a) OCT 9 - 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945, at 11:55 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh N. McNally M.D. Medical Examiner.
Date signed 10/8/45

VS 151

PRINT WITH PEN AND INK. WRITE PLAINLY. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33059

Registered No. 1288

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DUA Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1895

8. AGE: Years	Months	Days	If less than one day
50	1	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William H. Saunders
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Watkins
15. Birthplace Md.

16 (a) Informant Mary E. Reynolds
(b) Address 511 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1443 Brantley Ave

19 OCT 9 1945 (Date rec'd by registrar) (b) Huntingtown, Williams, M.F. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945 at 1.00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. Wallace M.D. Medical Examiner.
Date signed 10/9/45

VS 151

G33060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G33060 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Apts.

(c) Hospital or institution: 40th. St-Beech Av.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Carroll

(c) City or town Upperco (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME Julia Ernst Walker

3 (b) If veteran, name war ******* | 3 (c) Social Security Account No. ******

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence L. Walker

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 12-1900

8. AGE: Years 45 | Months 4 | Days 25 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER 12. Name: Conrad Ernst

13. Birthplace: Baltimore

MOTHER 14. Maiden Name: AMELIA KIHN

15. Birthplace: GERMANY

16 (a) Informant: Clarence L. Walker

(b) Address: Upperco, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 10 45 (month) (day) (year)

(c) Cemetery or crematory: LOUDON PARK

Location:

18 (a) Funeral director: Chas F EVANS · Son Inc

(b) Address: 118 W MT. ROYAL AVE.

19 (a) OCT 9 1945 (Date received by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1945, to 10/7 1945, and that I last saw h[er] alive on 10/5/45 19

Immediate cause of death	Duration
Carcinoma of Brain, metastatic	7 mo
Due to Carcinoma of Breast	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 3/26/45

Major findings of operation: metastatic Carcinoma of brain

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M.

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)

(e) Means of injury —

23. Signature: Francis W. Gluck M. D.

Address 715 Park Ave Date signed 10/8/45

VS 150

X

633051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633051 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2742 W. Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2742 W. Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine V. A. Staub

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Victor L. Staub
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1889

8. AGE: Years	Months	Days	If less than one day
56	5	21	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name George H. Litz
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ostendorf
15. Birthplace Md.

16 (a) Informant Victor L. Staub
(b) Address 2742 Mosher St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Road
18 (a) Funeral director Harry A. Mitzel
(b) Address 401 Edmondson Ave.
19 (a) (b)

OCT 9 1945 Huntington Hillcrest Reg. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1945, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/1944, to 10/7/1945, and that I last saw her alive on 10/7/1945.

Immediate cause of death: Hypertension cardio vascular disease. — Duration: 1 yr 20 days
Due to —
Due to —
Other Conditions none
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Leslie Mitzel M.D.
Address 426 Hamburg St Date signed 10/9/45

X

G33052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 179X

Registered No. G33052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 E. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Verna M. Brown

MEDICAL CERTIFICATION

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

20. DATE OF DEATH October 8, 1945 at 10:45 P. M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1943

8. AGE: Years	Months	Days	If less than one day: hr.	min.
2	2	26		

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation None
11. Industry or business

FATHER — 12. Name	Vernon M. Brown
FATHER — 13. Birthplace	Maryland
MOTHER — 14. Maiden Name	Myrtle Woodside
MOTHER — 15. Birthplace	Maryland

16 (a) Informant Vernon M. Brown
(b) Address 2201 E Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1945 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cem (Hampden) Location Baltimore Md.

18 (a) Funeral director Kenneth Donovan
(b) Address 3615-17 Chestnut Avenue

19 (a) (Date received by registrar) OCT 9 1945 Huntington Williams M.D.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pierotoxin & Veratrine poisoning

Due to Delousing agent "Kil-Ve"

Other Conditions (none)

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 8 at — 1:31 P. M.
(b) Where did injury occur? 2201 E. Lombard St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Undetermined.

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed Oct 9, 1945.

VS 151

X Skitarelic

633063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

633063 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 Mends Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 24

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Mends Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul E. Murphy

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Agnes V. Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 - 1876

8. AGE: Years 69 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Insurance

FATHER 12. Name Joseph F. Murphy

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Harretta A. Ferandini

15. Birthplace Baltimore, Maryland

16 (a) Informant Joseph Murphy (Son)

(b) Address Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10-45 (month) (day) (year)

(c) Cemetery or crematory St Charles

Location Pikesville, Md.

18 (a) Funeral director Frank H. Mewell

(b) Address Pikesville, Md.

19 OCT 9 - 1945 (Date rec'd by registrar) Lucy Lee Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9th 1945, at 12 05 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions Dependency.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9- at 12.05 A.M.
(b) Where did injury occur? 3314 Mends Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Asphyxiated by Kitchen Stove, Illuminating Gas

23. Signature Howard J. Mellers M.D.
Medical Examiner.

Date signed 10/8/45

VS 151

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G33064

AB-96484

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G33064 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 North Exter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Laughlin

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5- 1890?or1889?

8. AGE: Years	Months	Days	If less than one day
55?or 56?	4	3	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard J. Laughlin (D)
13. Birthplace New York

MOTHER
14. Maiden Name Sarah Quinn (D)
15. Birthplace New York

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Philadelphia Pa

18 (a) Funeral director Patterson Funeral Inc
(b) Address 2417 E. Monument St
(c) Thurlington Williams, M.D. Registrar
OCT 9 - 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-8 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1945 to 10-8 1945, and that I last saw him alive on 10-8 1945.

Immediate cause of death	Duration
cerebral hemorrhage, cause unknown	
Due to arteriosclerosis	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address BCH Date signed 10/

VS 150

83a

G33065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G33065 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4902 York Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4902 York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis E Hambach

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Mary E Hambach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1855

8. AGE: Years	Months	Days	If less than one day
90	7	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Hambach
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Martin Mayhill
(b) Address 4902 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 1219 E Fayette St

19 (a) (Date received by registrar) (b) Huntington Williamsport Md Registrar

OCT 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-1945 to 10-8-1945, and that I last saw him alive on 10-8-1945.

Immediate cause of death Uremia — Duration 5 days

Due to Arteriosclerotic cardio renal disease — Duration Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno B. Sybert M. D.
Address 2802 Hartford Rd Date signed 10-9-45

G33066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33056 Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2735 W Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 W Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie C Young

3 (b) If veteran, name war W
3 (c) Social Security Account No. xxx

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 1882

8. AGE: Years 63 | Months 7 3 | Days 5 3 | If less than one day hr. min.

9. Birthplace Westminster
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nelson Beaver
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Lizzie Stover
15. Birthplace Washington Md

16 (a) Informant Mrs Hugh Truitt
(b) Address 231 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Fuhrman Co Inc
(b) Address 1219 E Fort Ave

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945 at 12 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1944 to Oct 8 1945 and that I last saw h[illegible] alive on Oct 6 1945.

	Duration
Immediate cause of death: Generalized carcinomatosis	6 months
Due to Carcinoma of uterus	2 yrs.
Due to Carcinoma of breast	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 1944 – May 1945
Major findings of operation Sept 1944 uterine carcinoma May 1945 metastatic carcinoma of abdominal organs
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W Michel M. D.
Address 7901 Edmondson Ave Date signed 10 8 1945

VS 150

0 X

480708 G33057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33057 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Princeton (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Palmer Square (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold W. Read

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Marian Brown Read
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-27-02

8. AGE: Years	Months	Days	If less than one day
43	5	12	hr. min.

9. Birthplace Des Moines Iowa (Town, county, and state)
10. Usual Occupation Research - Vice-Pres.
11. Industry or business Opinion Research Corp.

FATHER
12. Name Archibald E. Read
13. Birthplace Iowa

MOTHER
14. Maiden Name Laura Trissel
15. Birthplace Ky.

16 (a) Informant Reads.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory Princeton Cem.
Location Princeton, N. J.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 9 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-9- 1945, at 1225 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-20 1945 to Oct. 9 1945 and that I last saw him alive on Oct-9 1945.

Immediate cause of death Infarction of myocardium — Duration 1 hr.

Due to Thrombosis of arteriosclerotic coronary artery

Due to

Other Conditions probable renal lithiasis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R. Milnor M. D.
Address Johns Hopkins Hosp. Date signed 10-9-45

VS 150

Dr. William R. Milnor X

633068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633068 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Canterbury Rd and 39th St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME DELLA M. HEISSE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edwin W. Heisse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name John Grayton Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester Anne Hyrock
15. Birthplace Maryland

16 (a) Informant Lt. Col. John W. Heisse
(b) Address 220 Gooddale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Instructor Williams, M.D. (Registrar)
(Signature of local registrar)

OCT 9 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945, at 10 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 8 1945, and that I last saw her alive on Oct 8 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic hypertensive Cardiovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kilpatrick Jr. M. D.
Address Union Memorial Hosp. Date signed 10-9-45

G33069 — BALTIMORE CITY HEALTH DEPARTMENT — G33069 Registered No.

CERTIFICATE OF DEATH 1/31a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie E. Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Rev. J. Thomas Hart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1874

8. AGE: Years	Months	Days	If less than one day
70 67	9	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry A. Booth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Harris
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Grace B. Hart
(b) Address 319 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 10-12-1945 (Date received by registrar) (b) Herrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1945, at 11 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1945 to 10/8 1945
and that I last saw her alive on 10/8 1945

Immediate cause of death	Duration
Uraemia	
Due to Chronic Nephritis	
Due to	
Other Conditions Cholecystitis & Chole-lithiasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 10/8/45

VS 150

G33070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

G33070
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 E 30th St
(c) Hospital or institution:

9 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 E 30th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Caroline Mary Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John H. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20 1853

8. AGE: Years	Months	Days	If less than one day
91 89	11/10	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Leonard Kurz.
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant J. Arthur Weber
(b) Address 2054 Kennedy ave

17 (a) Burial (b) Date thereof Oct 10th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Pulaski Hwy

19 (a) Date received by registrar (b) Huntington Williams, M.D. Registrar

OCT 9 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1945, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Oct 7 1945, and that I last saw her alive on Oct 6 1945.

	Duration
Immediate cause of death Bulbar Palsy	2 days
Due to Generalized Paralysis	10 yrs ?
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Gracyk, M.D.
Address 108 Biddle St Date signed Oct 8 1945

X

G33071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5407 Summerfield
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5407 Summerfield (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Greif

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth Greif

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Mar 15 1876

8. AGE: Years 69 | Months 6 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Mill Mngr

FATHER 12. Name John Greif

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Becker

15. Birthplace Germany

16 (a) Informant Elizabeth Greif

(b) Address 5407 Summerfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Orleans St

19 (a) 945 (Filed by registrar) (b) Huntington Williams M.R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Oct 7 1945, and that I last saw h alive on Oct 7 1945.

Immediate cause of death: Coronary Thrombosis

Due to: Generalized Arteriosclerosis — Duration 3 yrs

Due to: — 5 yrs

Other Conditions Parkinson's Disease — 20 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M.D.

Address 4930 Belair Rd Date signed Oct 8, 1945

VS 180

G33072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G33072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3418 Bancroft RD
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 WEEK

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington, DC (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Mass. ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) NO
If yes, name country

3 (a) FULL NAME AMELIA BAER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife ALPONM. BAER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace NEW YORK CITY (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business ✓

FATHER
12. Name SIMON DINKLEPILD
13. Birthplace GERMANO

MOTHER
14. Maiden Name MERYE. NORDLING
15. Birthplace FRANCE

16 (a) Informant Mrs. Eugene Yaney
(b) Address 3700 N 13th. AVE

17 (a) (Burial, cremation, removal) (b) Date thereof 10-9-45 (month) (day) (year)
(c) Cemetery or crematory Washington Hebrew
Location D.C.

18 (a) Funeral director D. Dangansky Son
(b) Address 3501-14th St NW

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1945 at 11a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945 to Oct 9 1945, and that I last saw h[illegible] alive on Oct 9 1945.

Immediate cause of death Cerebral Hemorrhage. — Duration Sudden

Due to Hypertension — 25 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 1720 Eye St. N.W. Date signed 10/9/45 M. D.

X

G33073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95B

G33073
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Stansbury Manor (If outside city or town limits, write RURAL and give town)
(d) Street No. D 6 Beech Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William E. Hamilton
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) March 14, 1911

8. AGE: Years	Months	Days	If less than one day
34	6	24	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter D. Weber
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Irene F. Fisher
15. Birthplace California

16 (a) Informant Hospital Records
(b) Address

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct 10/45 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director John O. Mitchell Sons Co.
(b) Address 1900 Huntington Ave. Baltimore, Md.

19 (a) Oct 9 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1945, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 7 1945, to October 8 1945, and that I last saw her alive on October 8 1945.

Immediate cause of death: PUlmonary edema — Duration

Due to Heart failure

Due to Rheumatic heart disease

Other Conditions Pregnancy, 16 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nicholson T. Eastman M. D.
Address Johns Hopkins Hospital Date signed 10-9-45

X

633074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

633074

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 173 Cromwell St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 173 Cromwell
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F Blumline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married.

6 (b) Name of husband or wife Mary Ciesel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
Abt 71	-	-	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name Wm Blumline
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs J. Ittner
(b) Address 16 N. Bernice Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 10 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Loudon Highway Md

18 (a) Funeral director J. J. Foley Sons
(b) Address 518 Light St.

19 OCT 10 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945, at 8 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 10 1945 to Oct 8 1945.
and that I last saw alive on Oct 8 1945.

Immediate cause of death	Duration
Carcinoma of face	Sixty
Due to Exhaustion	1 hr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Compost

Address 16 N. Hanover Date signed 10/9/45

VS 180

633075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Kensington (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John F. Kellaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Sarah E. Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
77	—	—	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired R.R.
11. Industry or business

FATHER 12. Name Noah Kellaugh.
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah E. Leonard
15. Birthplace Unk

16 (a) Informant Bernard F. Kellaugh
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12/45 (month) (day) (year)
(c) Cemetery or crematory Byrnes
Location Kensington

18 (a) Funeral director C. H. Zeh & Bro
(b) Address Baltimore Md

19 (a) Date received by Local Registrar OCT 10 1945 (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 9 1945, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945, to 10 - 9, 1945, and that I last saw him alive on 10-9 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Myocardial fibrosis	
Due to	
Other Conditions Pulmonary tbc.	

(Include pregnancy within 3 months of death)

Date of operation 10-9-45
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley R. Steinbach M. D.
Address Sinai Hospital Date signed 10-9-45

93D

633076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 633076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 N. Port St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 N Port St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S. Bottomley

3 (b) If veteran, name war No
3 (c) Social Security Account No. 212-03-2289

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Catherine Bottomley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6- 1876

8. AGE: Years	Months	Days	If less than one day
69	9	3	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Chesapeake Stove Co

FATHER
12. Name James Bottomley
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Catherine May Maydwell
(b) Address 3626 Cloverley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

OCT 10 1945 (Date received by local registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1945 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Oct 9 1945, and that I last saw h[illegible] alive on Oct 8 1945.

Immediate cause of death Carcinoma Sigmoid — Duration 14 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G Fa Stevens M. D.
Address 3878 Harford Rd Date signed 10-9-45

VS 150

X

HA 554 ✓ G33077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Balton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Halsey

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife (if married, widowed, or divorced) Mary Tramontana

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	19	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER 12. Name George Shepard Halsey
13. Birthplace At Sea

MOTHER 14. Maiden Name Thomasen Lovland
15. Birthplace Trondjem

16 (a) Informant Mr. George H. Halsey
(b) Address 2526 W Annursley Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Greer Mount
Location Baltimore, Md

18 (a) Funeral director Wilson City Funeral Home
(b) Address 1219 E Fayette St

19 (a) OCT 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1945, at 11:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1945, to Oct 8 1945, and that I last saw him alive on Oct 8 1945.

Duration

Immediate cause of death Respiratory failure
Due to Hematthorax
Due to Fractured rib due to a fall
Other Conditions A S H D
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Oct 2, 1945 at ? P.M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? no
(e) Means of injury fall & blow.

23. Signature J. Frank Supplee, III
Address Union Memorial Hospital Date signed 10/8/45 M. D.

VS 150

For: C. J. Lubinski, M.D. B. Statarski M.D.

G33078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

Registered No. G33078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1a mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. [redacted] Malmquist

3 (b) If veteran, name war No
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Capt. Carl Malmquist
6 (c) If alive, give age? years
7. Birth date of deceased (mo., day, yr.): June 19, 1895
8. AGE: Years 50 | Months 3 | Days 20 | If less than one day ____ hr. ____ min.
9. Birthplace: Texas (Town, county, and state)
10. Usual Occupation: house wife
11. Industry or business

FATHER
12. Name: Cassidy Snead
13. Birthplace: Kentucky

MOTHER
14. Maiden Name: Mary Roug
15. Birthplace: Kentucky

16 (a) Informant: Carl C Malmquist
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or crematory: Dallas
Location: Texas

18 (a) Funeral director: Wm Cook Inc
(b) Address: 12-2 St. Paul St

OCT 10 1945 (Date received by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1945, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1945 to Oct. 9 1945 and that I last saw h[illegible] alive on Oct. 9 1945

	Duration
Immediate cause of death: Coma	
pneumonia	
Due to: Carcinoma of tongue	
with metastases	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Crawford N. Fitzpatrick, Jr. M. D.
Address: Union Memorial Hosp. Date signed 10-7-45

VS 150

X

633079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. 633079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 31 EAST 21 ST ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State PA (b) County

(c) City or town COCHRANVILLE
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN MONROE WAGNER

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife FRONNIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 23, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	16	hr. min.

9. Birthplace INDEPENDENCE, VA.
(Town, county, and state)

10. Usual Occupation FARMER

11. Industry or business RETIRED

FATHER

12. Name ADAM WAGNER

13. Birthplace VA.

MOTHER

14. Maiden Name MARY ANN (UNKNOWN)

15. Birthplace VA

16 (a) Informant JOHN WAGNER

(b) Address YORKLYN, DEL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof OCT. 10, 1945 (month) (day) (year)

(c) Cemetery or crematory FALL MANNER

Location COCHRANVILLE, PA.

18 (a) Funeral director WILLIAM COOK INC

(b) Address 1217 ST. PAUL ST.

19 OCT 10 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 9 1945, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 9 1945 and that I last saw him alive on Oct 7 1945

Immediate cause of death	Duration
Carcinoma of Stomach	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Jack J. Singer M.D.

Address 50 E 2 North Ave Date signed 10-9-45

VS 180

G33080 X ✓ G33080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore County (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Beatley Springs, Md.
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cora May Wilson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed or divorced: Widow
6 (b) Name of husband or wife: Abram R. Wilson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 28, 1873
8. AGE: Years 72 | Months 7 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business None

FATHER
12. Name Charles Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Pennsylvania

16 (a) Informant Daughter
(b) Address Beatley Springs, Md.
17 (a) Burned (Burial, cremation, or removal) (b) Date thereof 10/12/45 (Month) (day) (year)
(c) Cemetery or crematory [redacted] Baltimore Co., Md.
Location
18 (a) Funeral director Jake Hartenstein
(b) Address New Freedom, Penn.
19 (Date rec'd by Registrar) OCT 10 1945 (b) Huntingtown Williams Md (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/45 19 45 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30/45 19 to 10/9/45 19, and that I last saw her alive on 10/9 19 45.

Immediate cause of death: Acute heart failure
Due to: Coronary Occlusion
b
Due to: Cholecystitis and Cholelithiasis (removed at operation)
Other Conditions: Possible Carcinoma of Pancreas.
(Include pregnancy within 3 months of death)
Date of operation 9/5/45
Major findings of operation: Cholelithiasis + Cholecystitis probably Carcinoma of Pancreas & gall bladder
of autopsy: Not obtained

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Gorham
Address University Hospital Date signed 10/9/45

X

G33031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33031 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fayette & Holiday – Armistead
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia (Town, county, state or country)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Park
Location Woodlawn Mem Park

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1945, at 2:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945, to 10/9 1945, and that I last saw h[illegible] alive on 10/9 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to coronary sclerosis	
Due to Cerebrovascular renal vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isabella L. Lauer M. D.
Address Franklin & Fayette Sts Date signed 10-9-45

G33032

4 HB96530

G33032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Leadenhall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabelle Magwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife William Magwood (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1906

8. AGE: Years	Months	Days	If less than one day
39	4 5	17	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Davey Johnson
13. Birthplace S. C.
MOTHER 14. Maiden Name Evelyn Bennett
15. Birthplace S. C.
16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 10 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. h. C., Md
18 (a) Funeral director Isaac L. Brown Son
(b) Address 108 W Montgomery St Huntington, W. Va.
19 OCT 10 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945 to Oct. 5 1945, and that I last saw her alive on Oct. 5, 1945

Immediate cause of death	Duration
Intestinal obstruction	3 mos.
Due to Tuberculous Peritonitis	
Due to	
Other Conditions Pulmonary Tuberculosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Thomas J. O'Neill M. D.
Address Balto. City Hospitals Date signed 10-5-45

VS 150

G33083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33083

Registered No.

HR #96386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 818 S. Sharp St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Jeremiah Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1887

8. AGE: Years	Months	Days	If less than one day
57	9	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jeremiah Palmer
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet Queen
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 10 45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location Balto City

18 (a) Funeral director Isaac L. Brown Sons
(b) Address 109 N Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 10 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1945, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Oct. 5 1945, and that I last saw him alive on Oct. 5, 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardio vascular disease	
Due to	
Other Conditions Arteriosclerosis pneumonia (bronchial)	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Jonathan Woodward M. D.

Address BCH Date signed 10/5/45

633034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 0

Registered No. 633034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Wheeler Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Alper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 4 1892

8. AGE: Years	Months	Days	If less than one day
53		5	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Post Office Clerk

FATHER
12. Name Boris Alper
13. Birthplace Russia

MOTHER
14. Maiden Name Etta ?
15. Birthplace Russia

16 (a) Informant Dora Alper
(b) Address 1907 Wheeler

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Betrayer Washington Rd Cemet
Location Washington Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

(a) OCT 10 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 2.30

20. DATE OF DEATH October 9 1945, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1945 to Oct. 9 1945. and that I last saw h[illegible] alive on 9-11-1945.

Immediate cause of death: Acute Coronary thrombosis — Duration: 4 hrs.

Due to: old Coronary art disease — Duration: few years

Due to:

Other Conditions: arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address [illegible] Date signed 10/9/45

X

633035 ✓ 633035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 St James St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 St. James (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie L. Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant John C. Woods

(b) Address 1223 St James St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cemetery

Location Baltimore

18 (a) Funeral director Robert E. Williams

(b) Address 1515 McCulloh St, Baltimore, Md.

OCT 10 1945 (b) Huntington, West Virginia

(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1945, at 1:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1 19 to 10/6 19, and that I last saw h[illegible] alive on 10/6 19

Immediate cause of death: Lobar Pneumonia — Duration 1 wk

Due to Exposure & Colds

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas. R. Blake M. D.

Address 1327 N. Central Ave Date signed 10/9/45

VS 150

633086

633086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 47147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 No Fulton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 No. Fulton Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wells

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife Robert Wells
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Charlestown Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Frank Bottdley
13. Birthplace Charlestown Md.

MOTHER
14. Maiden Name Nancy Stewart
15. Birthplace Charlestown Md

16 (a) Informant Margaret Cyrus
(b) Address 823 No. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A B Co Md

18 (a) Funeral director Robert O Williams
(b) Address 1515 McCulloh St

19 (a) Date received by local registrar OCT 10 1945 Robert O Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1945 at 11.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/4 1945 to 10/6 1945, and that I last saw her alive on 10/6 1945.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ronald Bolig Jr. M. D.
Address 501 Cherry Hill Rd Date signed 10/6/45

633037

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. 633037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mon 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs 6 mos 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. University Pkwy. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Clara Estelle Shafer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: ?

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 3/9/1884

8. AGE: Years 64 | Months 6 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore City, Md. (Town, county, and state)

10. Usual Occupation Housewife, Retired

11. Industry or business

FATHER
12. Name Jacob C. Shafer
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah F. Horn
15. Birthplace Baltimore, Md

16 (a) Informant J. Fred. Shafer (Brother)
(b) Address 214 Chancery Road, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-11-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108-W-North Ave., City.

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

OCT 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/ 1945, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1945 to 10/8 1945, and that I last saw h.er alive on 8/10 1945.

Immediate cause of death	Duration
1) Possible Case of Uterus	?
2) Possible Metastatic Carcinoma (3 mos post operative Ca)	3 yrs.
Due to Cerebral metastases	
Due to gastrointestinal partial	1 month
Other Conditions obstruction due to Pancreatic glandular metastasis	

(Including pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Richard Compton M.D.
Address Hospital for Women Date signed 10/9/45

G33088

BALTIMORE CITY HEALTH DEPARTMENT 1577 G33088

CERTIFICATE OF DEATH 139865 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 N. Rutland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-45

8. AGE: Years	Months	Days	If less than one day
			hr. 28 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Louise Winkleman
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School OCT 9 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 10 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 19 45 at 9:20PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1945 to October 1 1945, and that I last saw h im alive on October 1 19 45.

Immediate cause of death congenital abnormalities, multiple — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hosp. Date signed 10-4-45

VS 150

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633039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

Registered No. 633039

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1242 E. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 8 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

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Per.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1945, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage due to tear tentorium cerebelli -

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham, M.D.
Medical Examiner.
Date signed 10-8-45

Howard J. Haussler, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

838 Registered No. 633090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5646 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5646 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES W. MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widowed

6 (b) Name of husband or wife Sarah F. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1865

8. AGE: Years	Months	Days	If less than one day
80	3	16	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business Retired

FATHER
12. Name Frederick Myers
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Walker
15. Birthplace Va.

16 (a) Informant Mrs. Wm. W. Richardson
(b) Address 5646 Belair Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Meth.
Location Chase, Md.

18 (a) Funeral director Lasseter Funeral Home
Address 5601 Belair Road

19 (a) OCT 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9th, 1945, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2/45 to 10/9/45, and that I last saw h[illegible] alive on 10/[illegible]/45.

	Duration
Immediate cause of death Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions Hypertension	2 days
Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Ferryman M. D.
Address 1710 E 32nd St Date signed 10/11/45

X

G33091 ✓ G33091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Barber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Hvy / Cleaner

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Christine Barber

(b) Address 1214 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) OCT 10 1945 (Date rec'd by Registrar) Huntington for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

40

20. DATE OF DEATH October 7 1945, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10/7/45 at 2 P. M.

(b) Where did injury occur? Pennsylvania Ave & Carey St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Knocked to ground during altercation

23. Signature Robert L. Graham M.D. Medical Examiner.

Date signed Oct. 9 1945

(over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33092

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 73

G33092
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Wilson st
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ernestine Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-44

8. AGE: Years	Months	Days	If less than one day
1	0	19	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Hopkins
15. Birthplace Virginia

16 (a) Informant Annie Hopkins
(b) Address 520 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Catonsville Md

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (Date rec'd by registrar) OCT 10 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1945, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1945 to 10-6 1945 and that I last saw her alive on 10-6 1945.

Immediate cause of death	Duration
Aplastic Anemia	1 Month
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Smithdeal M. D.
Address 718 Dolphin St Date signed 10-8-45

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G33093 BALTIMORE CITY HEALTH DEPARTMENT G33093

CERTIFICATE OF DEATH 1945

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Tyson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Turpin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65-			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Dorsey
(b) Address 704 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Hyltead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 10 1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1945, at 5-50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 10-6-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 633094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Monument & Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Kamerowitz (KAMEROW)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Mollie Rose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1870
8. AGE: Years 75 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Jane Foreman
(b) Address 2600 Springhill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-45 (month) (day) (year)
(c) Cemetery or crematory Adreyn Mt Carmel
Location German Hill Rd
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St
19 (a) (b) Huntington Williamsport, Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1945, at 5:15 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1945, to 10-9 1945, and that I last saw him alive on 10-9 1945.

Immediate cause of death: Myocardial Failure — Duration
Due to: Myocardial Infarction
Due to: Arteriosclerotic Heart Disease
Other Conditions: Pulmonary edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome R Herskin M. D.
Address Sinai Hospital Date signed 10-9-45

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G33095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33095
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Whitelock Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Whitelock Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE GOLDBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
female	W	Married

(b) Name of husband or wife Benjamin
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Joshua Rubin
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15. Birthplace Russia

16 (a) Informant Benjamin Goldberg
(b) Address 906 Whitelock St

17 (a) Burial (b) Date thereof 10-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling Sts

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1619 E Balto St

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/45 19 , at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L Davis M.D.
Medical Examiner.
Date signed 10/9/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

633096 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmont
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Woodsboro - Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick County
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Keaney Creager

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ George W. Creager
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1877

8. AGE: Years 68 | Months 3 | Days 19 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Keaney
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Claris
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret Creager
(b) Address Woodsboro - Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 13 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location Woodsboro Md

18 (a) Funeral director G C Barlow
(b) Address Walkersville Md

19 (a) Date received by Registrar OCT 10 1945 (b) Registrar Huntington Mitchell

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945 at 4 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 6, 1945, to October 10, 1945, and that I last saw her alive on October 10, 1945

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Hypertonic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation October 9 1945

Major findings of operation: Fibroid goitre.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Church Home Hospital Date signed Oct. 19 45

633097

633097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Registered No. 633097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2535 FAIT AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2535 FAIT AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE HORNIG

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife RHEINHOLD HORNIG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 22 1869

8. AGE: Years	Months	Days	If less than one day
76 77	0	18 16	hr. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name HERMAN NEUGEBAUER
13. Birthplace GERMANY

MOTHER
14. Maiden Name BERTHA LANGER
15. Birthplace GERMANY

16 (a) Informant FRIEDA HORNIG (DAUGHTER)
(b) Address 2535 FAIT AVE.

17 (a) BURIAL (b) Date thereof OCT. 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b)
(Date rec'd by registrar) Registrar
OCT 10 19 Huntington Williams, M.D.

vs 1sd

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 8 1945 at 1/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 8 1945
and that I last saw h[illegible] alive on Oct 8 1945

Immediate cause of death: Arteriosclerotic C.V. Disease
Myocardial Failure. — Duration: 10-5-45

Due to

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 802 S. Eaton Ave. Date signed 10-9-45

X

G33098 G33098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. Sunnyside Oak Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Jett
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-45

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edward Jett
13. Birthplace Md

MOTHER
14. Maiden Name Nina Lee
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received OCT 10 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1945, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1945 to Oct 9 1945 and that I last saw h alive on Oct 9 1945

Immediate cause of death Diaphragmatic Hernia

Due to Congenital

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Diaphragmatic hernia, Lt. Atelectasis both lungs

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harriet G. Guild
Address Johns Hopkins Hosp. Date signed 10/9/45

VS 150

G33099 AUGUSTUS G33099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 Seven St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Mt. Winans, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Seven St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P Augustus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1871

8. AGE: Years 73 | Months 11 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Grocer

FATHER
12. Name Charles Augustus
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Adell Bodyns
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Catherine Augustus
(b) Address 2210 Seven St, Mt. W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945 at 1209 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 8 1945, and that I last saw him alive on Oct 6 1945.

Immediate cause of death Valvular Heart Disease — Duration 2 wks.

Due to Chronic Nephritis — 6 mo.

Due to Arterio Sclerosis — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Williams M.D.
Address 8 Bullock Ave Date signed 10/9/45

VS 8

PRINTING WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53,100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. 6333 (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 W. Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 W. Barre St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Sarah Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-5-1885

8. AGE: Years	Months	Days	If less than one day
60	7	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Georgetown, D.C.

MOTHER
14. Maiden Name Emily Brooks
15. Birthplace Calvert Co., Md.

16 (a) Informant William Thomas
(b) Address 615 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-'45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 32-4 Schroeder St

19 (a) OCT 10 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 7 1945 and that I last saw her alive on Oct 6 1945.

Immediate cause of death Chronic Cardio-renal disease and Diabetes mellitus — Duration: about 6 years
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Roland W. Gaines M. D.
Address 507 W. Hamburg St Date signed 6/9/45

VS 150

G33:01 G33:01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Loch Arm
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Loch Arm (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Baynard Baynard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George W. Baynard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-1890

8. AGE: Years 55 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name William H. Baynard

13. Birthplace Talbot Doland

MOTHER 14. Maiden Name Davis

15. Birthplace West River, Md

16 (a) Informant George Baynard

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie B. Williams

(b) Address 322 N Schroeder St

OCT 10 1945 (Date rec'd by Registrar) Hunting for Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1945 to Oct 7 1945; and that I last saw him alive on Oct 7 1945.

Immediate cause of death Cerebral hemorrhage — Duration 7 day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature [illegible]

Address 704 Loch Arm Date signed Oct 8 1945

VS 150

G33:02 G33:02

G33102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 512 N Fremont Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 512 N Fremont Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lula Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife James Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-94

8. AGE: Years	Months	Days	If less than one day
51	6	23	hr. min.

9. Birthplace Jacksonville - Fla (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Jack C Collins

13. Birthplace Fla

MOTHER

14. Maiden Name Salina

15. Birthplace Florence - Ariz

16 (a) Informant James C Collins

(b) Address 512 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 - 10 - '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katy A. Williams

(b) Address 222 N. Schroeder St

OCT 10 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1945, at 4:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1 1945, to Oct 6 1945, and that I last saw h alive on Oct 6 1945.

Immediate cause of death Myocarditis — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible]

Address 512 N Fremont Ave Date signed 10/7/45

633103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

633103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Caroline St.
(c) Hospital or institution: Saint Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Barclay St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MISS ISABELLE A. RYAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1883

8. AGE: Years	Months	Days	If less than one day
62	---	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Lawrence F. Ryan
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Bridget Kane
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Margaret Ryan
(b) Address 1111 Barclay street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 18 W. Mt. Royal Ave

19 (a) (Date rec'd by Registrar) OCT 10 1945 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1945 at 5 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1945 to Oct 9, 1945 and that I last saw h[illegible] alive on Oct. 9, 1945

Immediate cause of death: Cardio-respiratory failure
Due to: Arterio-sclerotic
Due to: Cardio-vascular disease
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Pulley M.D.
Address 1460 N Broadway Date signed 10-9-45

633:04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1634 Registered No. 633:04

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Eastern ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Zielinski

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-4208

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Wiesbottles

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Regina Zelinski
(b) Address 2018 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11-40 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Balto. city

18 (a) Funeral director Wm. S. Stalkowski
(b) Address 2017 Eastern ave.

19 (a) OCT 10 1940 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1940, at 4:P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Self-inflicted gun shot wound

Other Conditions Unconscious

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-6- at P. M.
(b) Where did injury occur? 2018 Eastern ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gunshot wound, self inflicted

23. Signature Howard J. Wiesbein M.D.
Medical Examiner.
Date signed 10-9-40

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33:05

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33:05 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2794 Tivoly Ave.
(c) Hospital or institution:
9/6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2794 Tivoly Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILHELMINA (Minnie) KATHERINE SCHWEIKERT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Frederick C. Schweikert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1875

8. AGE: Years	Months	Days	If less than one day
69	11	8	hr. min.

9. Birthplace Bad-Nassau, Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Zimmerman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Meister
15. Birthplace Germany

16 (a) Informant Mr. LeRoy Schweibert
(b) Address 2794 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 10 1945

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct. 6 1945, and that I last saw h[illegible] alive on Oct 6 1945.

Immediate cause of death	Duration
Edema of Lungs.	
Due to Myocardial Insufficiency	4 mos. +
Due to Chronic Myocarditis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Stamper M. D.
Address 817 Medical Arts Date signed 10/8/45

VS 150

633:06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

633:06 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto - Md.
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Zillis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Frank W. Zillis

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1869

8. AGE: 77 Years 76 | Months - | Days 12 | If less than one day hr. min.

9. Birthplace Poland Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) 10/11/45 (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Earle V. Funkhouser
(b) Address 637 Washington Blvd

19 (a) 10-10-1945 Date received by Registrar (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 — 1945 at 6-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 — 1945, to Oct 8 — 1945, and that I last saw her alive on Oct 8 — 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 month
Due to Cerebral Arterio Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 10/10/45

X

633:07

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

633:07
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampstead Ave
(c) Hospital or institution Pinewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 E. 28th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Sadie Gephardt.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 5 - 1867
8. AGE: Years 78 | Months 2 | Days 4 | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or Business

FATHER
12. Name: Hon. W. Thompson
13. Birthplace: Ireland.

MOTHER
14. Maiden Name: Julia Goldie
15. Birthplace: Ireland.

16 (a) Informant: Mrs. M. Greeley
(b) Address: 510 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 12-45 (month) (day) (year)
(c) Cemetery or crematory: Mem. Bath
Location: Old Frederick Rd.

18 (a) Funeral director: Jno. A. McKown
(b) Address: 3610 E. Balto. St.

19 (a) (Date received by Registrar) (b) Registrar: Huntington Williams, M.D.

OCT 10 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 1943, to Oct 9 1945, and that I last saw h.. alive on Oct 8 1945.

Immediate cause of death	Duration
Arteriosclerosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A Dana Moore M. D.
Address: 3105 Belair Rd Date signed 10-10-45

X

460 6333:08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

6333:08

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Tampa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Union St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Valdez.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-31

8. AGE: Years	Months	Days	If less than one day
13 14	10	7	hr. min.

9. Birthplace Florida
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jesus Valdez.
13. Birthplace Fla.

MOTHER
14. Maiden Name Josephine Romanello
15. Birthplace Fla

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory
Location Tampa, Fla.

18 (a) Funeral director John O. Mitchell Sons, Inc.
(b) Address 1400 Linden Place

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia

10 1945

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 9 - 1945, at 10.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 19 1945 to Oct- 9 1945.
and that I last saw him alive on Oct- 9 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Acute myeloid leukemia	1½ mons.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.
Address J. H. H. (Harriet Lane Home) Date signed 10-9-45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G33:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33:09 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 Register Avenue
(c) Hospital or institution: Armacost Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Groveland Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Nanie Gordon Coy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George J. Coy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William E. Gordon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie McConn
15. Birthplace Baltimore

16 (a) Informant Avondale N. Gordon
(b) Address 2436 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave., Baltimore

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1945, at 9.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to 10/9 1945
and that I last saw h alive on 10/9 1945

Immediate cause of death Hypertensive Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Coe Polley M. D.
Address 5103 Harford Rd. Date signed 10/10/45

VS 150

G33110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33110

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Rochester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reverend John Massetti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	9	27	hr. min.

9. Birthplace Rochester New York (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name George Massetti
13. Birthplace Rochester, New York

MOTHER
14. Maiden Name Elizabeth Quigley
15. Birthplace Rochester, New York

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)

(c) Cemetery or crematory Macedon Cemetery
Location near Macedon, New York

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) 10 1945 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945 at 5:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1945 to Oct. 9 1945, and that I last saw h.i.m. alive on Oct. 9 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions General Arteriosclerosis with hypertension — annual years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian M. Alagna M. D.
Address 336 Windsor Ave. Date signed

G33111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G33111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY
(c) Hospital or institution: Church Home & Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] 165 N. Curley (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Yost, Baby Girl
3 (b) If veteran, name war NO
3 (c) Social Security Account No. NO
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. SINGLE
6 (b) Name of husband or wife NONE
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-3-45
8. AGE: Years | Months | Days 5 | If less than one day hr. min.
9. Birthplace BALTIMORE, Md. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name DONALD YOST
13. Birthplace CUMBERLAND Md.

MOTHER
14. Maiden Name RUTH CLARK
15. Birthplace MARYLAND

16 (a) Informant MRS. DONALD YOST
(b) Address 165 N. CURLEY ST. BALTO. MD.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 10 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 OCT 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1945 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-8 1945 and that I last saw h[illegible] alive on 10-8 1945

Immediate cause of death RESPIRATORY FAILURE — Duration
Due to PREMATURE BIRTH
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jenny B. Goodhart M. D.
Address Church Home & Hosp. Date signed 10-9-45

VS 150

3004

G33:12 ✓ G33:12

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2837 Mayfield
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 Mayfield (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MANIX — John Mannix

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ wife Ethel Lammart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17th 1869

8. AGE: Years 76 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county and state)

10. Usual Occupation Fireman (Retired)

11. Industry or business Balto. City F.D.

FATHER
12. Name Not Known
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Ethel Mannix
(b) Address 2837 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) 1945 (Registered by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/45 19 , at 12:55 AM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 10/8/45

Cover sign is especially important. Physicians: please write the causes of death clearly and legibly.

G33113 ✓ G33113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Hartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Hartz
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 23, 1894

8. AGE: Years	Months	Days	If less than one day
51	15	17	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Clothing manufacturer
11. Industry or business

FATHER
12. Name Moses Hartz
13. Birthplace Austria

MOTHER
14. Maiden Name Lena Sugar
15. Birthplace Austria

16 (a) Informant Louis Hartz
(b) Address 3504 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinsom & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945 at 2 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945 to Oct 10 1945 and that I last saw him alive on Oct 10 1945

Immediate cause of death Cerebro-vascular accident (hemorrhage, right).

Duration 4 days

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. A. Sard for Huntington Williams, M.D. M. D.
Address Union Memorial Hospital Date signed 10-10-45

Huntington Williams, M.D

X

G33114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G33114

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 N. Eugene ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine I. Fritz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife George C. Fritz
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) March 29-1905

8. AGE: Years	Months	Days	If less than one day
40	6	13 10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Belcher
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Susan Phenfer
15. Birthplace Baltimore Md.

16 (a) Informant George C. Fritz
(b) Address 1321 N. Eugene Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave
(c) Huntington Williams M.D.
(Date received by local registrar)

OCT 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1945 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945 to 10-8 1945, and that I last saw her alive on 10-8 1945.

Immediate cause of death	Duration
Sub-Arachnoid Hemorrhage	
Due to Hypertensive C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 10-8-45

VS 150

SHAFFAR

G33115 BALTIMORE CITY HEALTH DEPARTMENT ✓ G33115

CERTIFICATE OF DEATH 131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Kemble Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-22
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Kemble Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Shaffar

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Harry F Shaffer
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 5 1884

8. AGE: Years	Months	Days	If less than one day hr.	min.
61	7	4		

9. Birthplace Simmonsville Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business —

FATHER
12. Name Mayer Hill
13. Birthplace Simmonsville Md

MOTHER
14. Maiden Name Sarah Anne Thuter
15. Birthplace Simmonsville Md

16 (a) Informant Frank B Shaffer
(b) Address 1527 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Mowland Park
Location Baltimore Md

18 (a) Funeral director Wilborn Cook Inc
(b) Address 1217 E Fayette St

19 OCT 11 1945 (b) Huntington Wilborn, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1945, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 1945 to Oct 9 1945 and that I last saw h alive on Oct 9 1945

Immediate cause of death	Duration
Due to Chronic Myocarditis	1940
Due to Chr. Interstitial Nephritis	1940
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Mason M. D.
Address 1663 W North Ave Date signed 10/10/45

VS 150

X

633116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 ✓ Registered No. 633116

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 W Lower Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fayson E. Carroll

3 (b) If veteran, name war Spanish | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Bertie May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Eastport, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas E. Carroll
13. Birthplace Annapolis, Md

MOTHER
14. Maiden Name Fannie
15. Birthplace Annapolis, Md

16 (a) Informant Edgar Carroll
(b) Address 2218 Old Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Mathews & Son
(b) Address 1219 E Fayette St

19 (a) OCT 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10-1945, at 9:40 AM

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 10-10-45

X

633117

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1579

Registered No. 633117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Robinson A (Joyce Ellen Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	F	W	S

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/45

8. AGE: Years	Months	Days	If less than one day hr.	min.
		5		

9. Birthplace Md. Gen. Hosp Balto. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name J. Arnold Robinson
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Audrey C.
15. Birthplace Balto., Md.

16 (a) Informant Mr. J. Arnold Robinson
(b) Address 729 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 10 11 1945 (Date received by Registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1945 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 10 1945 and that I last saw her alive on Oct 5 1945.

Immediate cause of death Respiratory Collapse — Duration 5 days
Due to Cong. Structural Esophagus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Blue M. D.
Address Md. Gen. Hosp Date signed 10/12/45

VS 150

G33118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. 41st ST. BALTO-18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME KATHERINE P. CHINN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-03-5336

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	13	hr. min.

9. Birthplace NEW YORK (Town, county, and state)
10. Usual Occupation BOOK KEEPER
11. Industry or business MARYLAND CASUALTY Co.

FATHER
12. Name HENRY (later) CHINN
13. Birthplace ENGLAND (Birmingham)

MOTHER
14. Maiden Name KATE TAPLIN
15. Birthplace ENGLAND (Birmingham)

16 (a) Informant MR. LEONARD CHINN
(b) Address 510 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory St. John's Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1945 (Date rec'd by registrar) (b) Huntington Mitchell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1945, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945, to 10/10 1945, and that I last saw her alive on 10/10 1945.

Immediate cause of death	Duration
Heart failure	
Due to Auricular fibrillation	
Due to Arteriosclerotic CARDIAC DISEASE.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations: NONE
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas Stuhan D
Address Mercy Hosp Date signed 10/10/45

VS 150

G33119 ✓ G33119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2888 Kentucky ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-1
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? 60 years

3 (a) FULL NAME Charlotte Louisa Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married, widowed, or divorced~~: Widowed

6 (b) Name of husband or wife: James Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25-1872

8. AGE: Years 72 | Months 11 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Charles Rotenkoff
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Edward S. Sullivan
(b) Address 2888 Kentucky ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem
Location Baltimore

18 (a) Funeral director Jos J Herget & Son
(b) Address 3091 Kentucky ave

19 (a) (Date rec'd by Clerk) (b) Registrar

OCT 11 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9- 1945 at 6.34 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1945 to 10- 1945.
and that I last saw h[illegible] alive on 10-8-1945.

Immediate cause of death cerebral Hemorrhage -
Duration 4 mos

Due to Hypertension & Arterio Sclerosis
Duration 4 years

Due to
Duration

Other Conditions
Duration

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D. Sullivan M.D.
Address Medical Arts Bldg Date signed 10/10/45

633120 3

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

633120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2366 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2366 Washington Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL FALK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Ada May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 - 1884

8. AGE: Years	Months	Days	If less than one day
61	10	21	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Grocery
11. Industry or business

FATHER 12. Name Thomas P Falk
13. Birthplace Md

MOTHER 14. Maiden Name Annie Reinhardt
15. Birthplace Md

16 (a) Informant Ada M Falk
(b) Address 2366 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Rd
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2309 Wash Blvd

19 (a) (Date rec'd by Local Registrar) (b) Thurlington Williams, M.D. Registrar

OCT 11 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/45 19..., at 2:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 10/9/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33121 ✓ BALTIMORE CITY HEALTH DEPARTMENT 937 ✓ Registered No. G33121

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2445 Westport St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Westport (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Spielmann

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
md	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1859

8. AGE: Years	Months	Days	If less than one day
86	—	—	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Jacob.
13. Birthplace Germany

MOTHER
14. Maiden Name do not know
15. Birthplace Germany

16 (a) Informant Mrs Edwin Finnegan
(b) Address 2445 Westport St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2359 West Blvd

19 OCT 11 1945 (Date rec'd by registrar) (b) Huntington Hillsborough

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1945, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Oct 10 1945, and that I last saw him alive on Oct 9 1945.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	3 yrs
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schofield
Address 3 No Arlington Ave Date signed 10/10/45

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G331122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G331122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 923 S. Paca Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 S. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA E. MIDDLECOFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	21	hr. min.

9. Birthplace Baltimore County, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick F. Milvick
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Clay
15. Birthplace Maryland

16 (a) Informant William Middlecoff
(b) Address 923 S. Paca Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

OCT 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1939 to 10/10 1945, and that I last saw h[illegible] alive on 10/10 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Hypertensive Cardio Vascular Renal Disease	6 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight H. Lankford, M.D.
Address 675 Washington Blvd Date signed 10/11/45

X

633123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

633123 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 N. Forest Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 - 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 N. Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA WILHELMINA SHIPLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Aquilla J. Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Fritz Sandusky
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Kaiser
15. Birthplace Germany

16 (a) Informant Mrs. Alice Pfister
(b) Address 1327 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/45 (month) (day) (year)
(c) Cemetery or crematory Ward's Chapel
Location Randallstown, Md.

18 (a) Funeral director MM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b)
(Date rec'd by registrar) OCT 11 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1945 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 10 1945 and that I last saw her alive on Oct 9 1945.

Immediate cause of death Congestive Heart Failure — Duration 2 Wks
Due to Generalized arteriosclerosis — 3 yrs
Due to Hypertensive Cardiovascular — 10 yrs
Other Conditions Diabetes Mellitus — 12 yrs
Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos J Roberts M. D.
Address 4509 Liberty Heights Ave Date signed 10-11-45

G33124

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

479

G33124 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3225 Avon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Almeda V. Orendorff

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: John I. Orendorff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1870

8. AGE: Years	Months	Days	If less than one day
75	0	0	hr. min.

9. Birthplace: Finksburg, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Corbin
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Malinda Routzohn
15. Birthplace: Carroll Co., Md.

16 (a) Informant: Mr. Paul J. Orendorff
(b) Address: 3225 Avon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory: St. John's Cem.
Location: Westminster, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 11 1945 (Date received by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945, at 3 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 10 1945 and that I last saw her alive on Oct 10 1945

Immediate cause of death	Duration
Gen. Carcinoma	
Due to Carcinoma of lung	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. M. Candler M. D.
Address Md Gen Hosp Date signed 10-11-45

VS 150

X

G33125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G33125 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella J. Milburn

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex 7 | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert Milburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1896

8. AGE: Years 49 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name Robert Brooks

13. Birthplace md

MOTHER 14. Maiden Name Elizabeth Grayson

15. Birthplace md

16 (a) Informant Mary Lee

(b) Address 2104 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)

(c) Cemetery or crematory St Marys Co Md

Location Md

18 (a) Funeral director Lloyd L. Kelson

(b) Address 1303 Pulaski Street

19 (a) (Signature and title) (b) Huntingdon Pa

OCT 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Dec 1945, and that I last saw h[illegible] alive on Dec 9 1945.

Immediate cause of death: Coronary Thrombosis

Due to Congestive Heart failure

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence Oct 10 at 7 A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Emerson R. Milburn M.D.

Address 434 E 23rd Date signed Oct 10, 45

X

633126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 633126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Linwin St
(c) Hospital or institution: President Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 W. Lafayette
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Lyles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-16-63

8. AGE: Years	Months	Days	If less than one day
82	2	23	hr. min.

9. Birthplace Baltimore County, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Eliza
15. Birthplace Baltimore Co. Md.

16 (a) Informant Son
(b) Address 713 W. Lafayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Mrs. Francis V. Hemsley
(b) Address 578 W. Biddle St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 10-9 1945, and that I last saw her alive on 10-9 1945.

Immediate cause of death Hypostatic pneumonia — Duration

Due to Fractured left hip

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-17-45 at ? M
(c) Where did injury occur? 713 W. Lafayette (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no (Specify type of place)
(e) Means of injury Fell down stairs.

23. Signature J. Lindite. M. D.
Address 1514 Linwin St Date signed 10-10-45

Howard J. Mansueto, M.D. X

633127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

633127 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DEAD ON ARRIVAL - MERCY HOSP. ACCIDENT ROOM
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3230 E Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** RICHARD E BELT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May. 30 - 1935

8. AGE: Years	Months	Days	If less than one day: hr.	min.
10	4	11		

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Percy L. Belt.
13. Birthplace Nr Balto Md.

MOTHER
14. Maiden Name Mary M. Simpson
15. Birthplace Baltimore Md.

16 (a) Informant Mother
(b) Address 3230 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Old Frederick Rd

18 (a) Funeral director John L. Moran
(b) Address 3000 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Oct 10 1945 and that I last saw him alive on Oct 10 1945. Dead on Arrival

Immediate cause of death
Probable massive cerebral hemorrhage
Due to known to have a mid line cerebellar tumor

Duration
2 yrs

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E Beall M. D.
Address Mercy Hospital Date signed 10/10/45

VS-150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G33128 Registered No.

PRINT PLAINLY IN BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 526 Oxford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jamie Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/1913

8. AGE: Years	Months	Days	If less than one day
31	11	7	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Green
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Clark
15. Birthplace Md.

16 (a) Informant Elizabeth Clark
(b) Address 603 L. St. L.E. Apt. 7 wash, D.C

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Holy Ghost
Location Ogsie Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1945 to 10/7 1945 and that I last saw her alive on 10/6/45 19

Immediate cause of death	Duration
Pneumonia	
Embolism	
Due to Tuberculosis and Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Bailey M. D.
Address Mercy Hosp. Date signed 10/7/45

VS 150

G331129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G331129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4514 Arabia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Ensor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Fuchs

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6130

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna E. Fuchs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-1886

8. AGE: Years	Months	Days	If less than one day
59	8	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Assistant Foreman
11. Industry or business Gas & Electric Co.

FATHER
12. Name Henry Fuchs
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Steil
15. Birthplace Germany

16 (a) Informant Anna E. Fuchs
(b) Address 1417 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John G. Miller
(b) Address 2534 Jefferson St.

OCT 11 1945 Huntington Williams M.D. Registrar
(Date rec'd by city registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1945, at 3:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1945, to Oct 10 1945, and that I last saw h/m alive on Oct 10 1945.

Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Arteriosclerotic Cardio-Vasc. — ?
Due to Renal Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M. D.
Address 1206 E. Preston Date signed 10/11/45

VS 150

633:30

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 633:30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Md. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2323 Maryland Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Alvis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1945.

8. AGE: Years	Months	Days	If less than one day
		22	20 hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Preston Boardway

13. Birthplace Mass.

MOTHER 14. Maiden Name Margaret Blank

15. Birthplace W. Va.

16 (a) Informant Mrs. Alvis

(b) Address 2323 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11th 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.

Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill

(b) Address 1501 E. Fort Ave.

19 (a) OCT 11 1945 (Date rec'd by reg.) Registrar

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1945, at 9:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 9 1945, and that I last saw him alive on Oct 9 1945.

	Duration
Immediate cause of death Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature O. M. Crandell M. D.

Address Md. Gen. Hosp. Date signed 10-9-45

VS 150

X

2 Trans

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G33131

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Division Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Division Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob H. Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife: Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1889

8. AGE: Years	Months	Days	If less than one day
56	4	14	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Patrick Stevenson
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace unknown

16 (a) Informant Alice Stevenson
(b) Address 2121 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location

18 (a) Funeral director Mrs. Robert G. Ellis c/o Dft
(b) Address 1129 N. Carrollton Ave

19 (a) [illegible]
(Date rec'd by registrar) Harrington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1945, at 11 P. M. KS

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary embolism, bilateral

Rupture of right ventricle (agonal)

Due to Contusions & abrasions of right leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 10-1-45 at 6 P. 14/3 M.
(b) Where did injury occur? Division & Bloom Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Skotzelic M.D. Medical Examiner.
Date signed

VS 151

X

MUZIK.

633132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 633132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd Street

(c) Hospital or institution: Union Memorial Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Brooklyn Park (If outside city or town limits, write RURAL and give town)

(d) Street No. #4 - 12th Street. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby Girl Muzik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1945

8. AGE: Years ..... Months ..... Days 16 hrs. ..... If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name Frank J. Muzik

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Irene Smith

15. Birthplace Baltimore, Md.

16 (a) Informant Father

(b) Address .....

17 (a) Burial (burial, cremation, or removal) (b) Date thereof OCT 11, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Road

18 (a) Funeral director E. Schmeisser

(b) Address 631 E. Madison St.

19 OCT 11 1945 (Date rec'd by Local Reg.) (b) Harrington for Williamia Mohr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25/1945 to 10/10/1945 and that I last saw h[illegible] alive on 10/10/1945.

Immediate cause of death Bronchopneumonia

Due to Prematurity

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Mary Raymond Streeter M. D.

Address ..... Date signed .....

VS 150

G33133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33133

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: University Hospital 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore, Md. 2

(If outside city or town limits, write RURAL and give town)

(d) Street No. 708 Harvey St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3 (a) FULL NAME George C. Wiegard

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-03-0615A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Ida M. Wiegard (nee Rausch) 6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 6, 1878

8. AGE: Years 67 | Months 3 | Days 3 | If less than one day: hr. ..... min.

9. Birthplace Balto., Maryland (Town, county, and state)

10. Usual Occupation Retired Bartender

11. Industry or business Saurin's Tavern

FATHER — 12. Name George Wiegard

13. Birthplace Balto., Md

MOTHER — 14. Maiden Name Mary Bleum

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary A. Lewis (Daughter)

(b) Address 708 Harvey St., Balto. 30, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.

Location Govans, Md.

18 (a) Funeral director Edward Evans

(b) Address 4005 Charles St., Balto 30, Md

OCT 11 1945 (Date rec'd by registrar) (b) Huntingtown, Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1945, at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1945, to Oct 9 1945, and that I last saw him alive on Oct 9 1945.

Immediate cause of death Cardio Respiratory Failure ~~Cerebral Hemorrhage~~

Due to Cerebral Hemmorrhage

Due to Hypertension Cardio-vas. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

.....

of autopsy:.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....

(e) Means of injury.....

23. Signature W. M. Scott M. D.

Address University Hosp. Date signed Oct 10, 1945

VS 150

633134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 633134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 352 + Seventh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 352 + Seventh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean Margaret Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1928

8. AGE: Years 17 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation School

11. Industry or business None

FATHER
12. Name Harry W. Johnson
13. Birthplace Austin, Texas

MOTHER
14. Maiden Name Anna Johnson
15. Birthplace Proctor, Vermont

16 (a) Informant Mr Harry Johnson
(b) Address 352 + Seventh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Annapolis Blvd.

18 (a) Funeral director John F Henry Inc
(b) Address 716 Eight St.

19 (a) OCT 11 1945 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9, 1945 at 2:56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1945 to Oct 9 1945 and that I last saw he alive on Oct 8 1945.

Immediate cause of death: Respiratory failure — Duration

Due to: Pulmonary tuberculosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Shorofsky M.D.

Address 601 N. Monroe St. Date signed 10/11/45 M. D.

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633135
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. 2 Walker Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Fisher

3 (b) If veteran, name war None

3 (c) Social Security Account No. 215-05-2471

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mollie May Fisher

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 11 - 1886

8. AGE: Years 59 | Months 8 | Days 29 | If less than one day — hr. — min.

9. Birthplace Baltimore County Maryland
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Md. Engraving Co.

FATHER
12. Name William Fisher
13. Birthplace Balto. Co. Maryland

MOTHER
14. Maiden Name Anna Rebecca Hoeller FULLER
15. Birthplace Maryland

16 (a) Informant Anna Rebecca Harmon
(b) Address Heller Rd. Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Dec 12-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frank A. Purrell
(b) Address Pikesville, Md.

19 (a) (Date rec'd by Registrar) **(b)** Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1945, to 12-9 1945, and that I last saw him alive on 12-9 1945.

Immediate cause of death Cerebral Embolism

Due to Arteriosclerotic cardio-vascular disease

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp. Date signed 12-9-45

G33136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

G33136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 Derby Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Ignatz Roth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1876

8. AGE: Years	Months	Days	If less than one day: hr.	min.
69	5	19		

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Philip Schneider
13. Birthplace Hungary

MOTHER
14. Maiden Name Betty Brian
15. Birthplace Hungary

16 (a) Informant Mr. Ignatz Roth
(b) Address 2321 Derby Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Bath. Md.

18 (a) Funeral director Sonneborn & Son
(b) Address 902 Eutaw Place

19 (a) OCT 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945 to 10-11-1945, and that I last saw her alive on 10-11 1945.

Immediate cause of death ~~Cardiac failure~~ Gastro-duodenal obstruction — Duration

Due to ~~Pneumonia~~

Due to Metastatic fibrosarcoma of ~~gall bladder~~ omentum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ~~Some~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert F. Wasserman M. D.
Address Sinai Hospital Date signed 10/14/45

VS 150

G33137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

G33137

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: Saint Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Harford Ave. (If rural give location)
(e) Citizen of foreign country? N. (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. PHILLIPINA SEILER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Seiler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1869

8. AGE: Years	Months	Days	If less than one day
76 75	11	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Theo. Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Feldt
15. Birthplace Germany

16 (a) Informant Charles Seiler
(b) Address 2622 Harford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Rural

18 (a) Funeral director Uellrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

OCT 11 1945
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1945 to Oct. 9, 1945 and that I last saw h[illegible] alive on Oct. 8, 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Cerebro-vascular accident.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Riley
Address 1400 N Caroline Date signed 10-9-45

X

633138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 633138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3309 TOONE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 TOONE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. WEBER

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-3352

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife EMMA J. WEBER
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) JAN. 14, 1883

8. AGE: Years	Months	Days	If less than one day
62	8	26	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation RETIRED.
11. Industry or business

FATHER
12. Name LOUIS WEBER
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ANNA BOZMAN
15. Birthplace BALTO., MD.

16 (a) Informant EMMA J. WEBER (WIFE)
(b) Address 3309 TOONE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-12-45. (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM. Location EASTERN AVE. RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Gait Ave.

19 (a) Date received by Registrar 10-11-1945 (b) Registrar's signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1945, at 7.50 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from June 1939 to Oct 1945 and that I last saw him alive on Aug 1945.

Immediate cause of death: Acute cardiac failure — Duration 4 hrs.
Due to: Arteriosclerotic Cardiovascular disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Stevens M.D.
Address 3402 Eutaw Date signed 10/11/45

G33139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 406 S. CLINTON ST.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 63 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County BALTO.

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 406 S. CLINTON ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: FREDERICK SHNEFSKI

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: MARY SHNEFSKI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 5 1868

8. AGE: Years 77 | Months 8 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business BROOM FACTORY

FATHER

12. Name KARL SHNEFSKI

13. Birthplace GERMANY

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace GERMANY

16 (a) Informant ANNA WIELAND (COUSIN)

(b) Address 1432 WOODALL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 13/45 (month) (day) (year)

(c) Cemetery or crematory SCHWARTZ

Location ODONNELL ST.

18 (a) Funeral director Reilly & Zeiler inc

(b) Address 403 S. WOLFE ST.

(a) (Signature of Registrar) (b) Registrar

OCT 12 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 10 1945, at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6-45 19..., to 10-10-45 19..., and that I last saw h.im alive on 10-9-45 19...

Immediate cause of death: Cerebral thrombosis — Duration: 2 days

Due to: Exterminans

Due to:

Other Conditions: Carcinoma of Cervical Glands

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at ...M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John Costantino, MD

M. D.

Address 234 E. Monument St. Date signed 10-11-45

X

477302 G33140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 61 G33140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 & Sycamore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Jones.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Marion
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 1-17-1898.

8. AGE: Years	Months	Days	If less than one day
47	8	24	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Longshoreman Operator
11. Industry or business

FATHER 12. Name Marcellus Jones
13. Birthplace Md.

MOTHER 14. Maiden Name Florence Ravain
15. Birthplace Md

16 (a) Informant Rennda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Ga. & Fr. Co.

18 (a) Funeral director Sam'l. H. Chase Son
(b) Address 638 N. Gilmor St

19 (a) (Filed by registrar) Huntington Williams, M.D. (b) Registrar

OCT 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1945 at 8 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1945 to Oct 10 1945 and that I last saw him alive on Oct. 10 1945.

Immediate cause of death	Duration
Shock	
Due to ? embolus to mesenteric artery	
Due to Endocarditis	
Other Conditions diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John H. Green M.D.
Address Johns Hopkins Hospital Date signed 10/11/45

92E

G33141 BALTIMORE CITY HEALTH DEPARTMENT G33141
478720 CERTIFICATE OF DEATH 46B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belair (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank. Bergent.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) b-5-78

8. AGE: Years	Months	Days	If less than one day
69	4	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Peter F. Bergent.
13. Birthplace Md

MOTHER 14. Maiden Name Margaret J. Wood
15. Birthplace M.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Bond Shipbuilding
Location Elliott City Md

18 (a) Funeral director F.C. Ingenuskrom
(b) Address Ellicott City Md

19 (a) OCT 12 1945 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11. 1945 at 5.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 13 1945 to Oct-11 1945 and that I last saw him alive on Oct. 11 1945.

Immediate cause of death Advanced generalized carcinomatosis — Duration

Due to Ca of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 20, 1945

Major findings of operation: Ca of stomach & metastases

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W.H. Meyler M.D.
Address The Johns Hopkins Hosp Date signed 10-11-45

X

G33142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G33142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument and St. Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3443 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie JOFFE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife B. JOFFE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harris Getlin
13. Birthplace Russia

MOTHER
14. Maiden Name Shana Reba
15. Birthplace Russia

16 (a) Informant Milton Joffe
(b) Address 3443 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Shaarei Zedek
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1789 E. Balto St

19 (a) 10-1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12, 1945, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 10-12 1945 and that I last saw her alive on 10-12 1945.

Immediate cause of death Cachexia — Duration

Due to Carcinomatosis

Due to Carcinoma Cervix & Vesicovaginal fistula

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley P. Steinbach M. D.
Address Sinai Hospital Date signed 10-12-45

X

G33143

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G33143 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Fonaroff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)
10. Usual Occupation Hebrew Teacher
11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Chaj
15. Birthplace Russia

16 (a) Informant Dept Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Lemon Hill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) 10-12-1945 (Date received by registrar) (b) Registrar Washington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1945, to 10/11 1945, and that I last saw him alive on 10-11 1945.

Immediate cause of death Cerebral embolism — Duration

Due to Hypertension C-V Disease & Auricular fibrillation

Due to and congestive failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin Kreb M. D.
Address Sinai Hospital Date signed 10-11-45

G33144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

G33144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St • Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Holmes Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SNYDER, REBECCA (REBECCA SNYDER)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Isaac Snyder
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 65 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Margolis
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant George Snyder
(b) Address 2729 Callow Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)
(c) Cemetery or crematory Sinai Israel
Location Pimlico Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St
19 (a) (Date received by registrar) (b) Registrar

Huntington Hillcrest, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11, 1945 19— at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 19 45 to Oct 11 19 45, and that I last saw her alive on Oct 11 19 45.

Immediate cause of death	Duration
Cardiac failure	
Due to cystitis - ureteric lead dermal	
Due to	
Other Conditions uremia diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Schulz M. D.
Address Sinai Hospital Date signed 10/11/45

VS 150

93D

G33145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G33145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Crystal Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Kingston Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MARTINI

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	W	Widowed

6 (b) Name of husband or wife John Herman, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1881

8. AGE: Years	Months	Days	If less than one day
64	5 6	29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Davis
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Mauler
15. Birthplace Germany

16 (a) Informant John Herman Martini, Jr.
(b) Address Kingston Pk, Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Moreland memorial Cem.
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Registrar

OCT 12 1945 Huntingtown Athletic, MD

MEDICAL CERTIFICATION A. M.

20. DATE OF DEATH October 10 1945, at 12.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1945, to Oct. 10 1945, and that I last saw her alive on Oct. 10 1945.

Immediate cause of death — Duration
Diabetes — 10 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: no
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James F. Waite M. D.
Address 700 Eastern Ave Baltimore 24. Md Date signed 10/10/45

VS 150

633146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

633146

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2332 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth A. Appleby

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm D. Appleby

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.): Jan 21 1882

8. AGE: Years 63 | Months 8 | Days 14 | If less than one day: hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER 12. Name John McCartney ?

13. Birthplace

MOTHER 14. Maiden Name Mary Russell ?

15. Birthplace

16 (a) Informant William D. Appleby

(b) Address 2332 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13-1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balt Cy B M Walter

18 (a) Funeral director Pratt

(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1945, at 9 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Oct 10 1945 and that I last saw her alive on Oct 6 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arterio-Sclerosis	
Due to	
Other Conditions Coronary Thrombosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas S. Bowyer M. D.

Address Medical Arts Bldg Date signed

X

G33147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G33147 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Park Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Armstrong (John W.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Martha C. Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27 1896

8. AGE: Years	Months	Days	If less than one day
48	9	15	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Jack Armstrong
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Annie Buck
15. Birthplace Pennsylvania

16 (a) Informant Jack Armstrong
(b) Address 847 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location End of E. North Ave.

18 (a) Funeral director Elmer W. Coughlin & Son
(b) Address 924 E. Eager St.

19 (a) Date received by registrar OCT 12 1945 (b) Registrar Huntington Hitchcock, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1945, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-11 1945, and that I last saw him alive on 10-11 1945.

Immediate cause of death	Duration
BRONCHOPNEUMONIA.	
Due to ACUTE HEPATITIS (ETIOLOGY UNDETERMINED)	
Due to	
Other Conditions PERFORATED GASTRIC ULCER. CHRONIC OSTEOMYELITIS (LEFT FEMUR)	

(Include pregnancy within 3 months of death)

Date of operation 10-5-45

Major findings of operation: PERFORATED GASTRIC ULCER; HEPATITIS. BRONCHOPNEUMONIA.

of autopsy: ACUTE HEPATITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature James B. Little M. D.
Address The Church Home & Hosp. Date signed 10-11-45

VS 150

G33148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33148

Every item of information should be carefully supplied. The space where printed, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Street age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Macey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Edmond.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-27-96

8. AGE: Years	Months	Days	If less than one day
49.	8	15	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie ? ?
15. Birthplace Md.

16 (a) Informant Reeder.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Marley Road Ct
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) [illegible] Registrar Huntington Williams, M.D. Registrar

OCT 12 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-11-1945 at 1.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-10-1945 to Oct-11 1945. and that I last saw her alive on Oct-11 1945.

Immediate cause of death	Duration
Subarachnoid hemorrhage	Unknown
Due to	
Due to	
Other Conditions Pulmonary edema	Unknown

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maxwell Wilson M. D.
Address Johns Hopkins Hosp. Date signed 11 Oct '45

G33149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33149 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 W Mulberry St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 W Mulberry (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lettie Fleming

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Thomas Fleming

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1902

8. AGE: Years 43 | Months 4 | Days 13 | If less than one day hr. min.

9. Birthplace Selma Ala. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Lewis Pate

13. Birthplace Greensboro Ala.

MOTHER 14. Maiden Name Veney Calvert

15. Birthplace Greensboro Ala.

16 (a) Informant Thomas Fleming

(b) Address 1315 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-45 (month) (day) (year)

(c) Cemetery or crematory Arlington Memorial

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St

(Signature for Williams, M.R.)

19 1945 (Date rec'd by registrar) Registrar

OCT 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1945, to 10-7 1945, and that I last saw her alive on 10-6 1945.

Immediate cause of death: Coronary Thrombosis — Acute Myocarditis — Duration (Days) 2 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Jackson

Address 1200 N Calvert St Signed 10-9 1945

G33150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G33150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Herbert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Winfield G. Perrigo Peregoy (Winfield G. Peregoy)

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 1, 1892

8. AGE: Years 53 54 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: John C. Peregoy
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Julia A. Smith
15. Birthplace: Maryland

16 (a) Informant: Mrs. Julia A. Peregoy
(b) Address: 2555 Francis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Miller & Amoss
(b) Address: 2310 Liberty Heights Ave.

(c) Thurlington Williams Registrar (Signature of registrar)

239035
OCT 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945, at 9 P. M 15

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Acute Pulmonary Edema, Bronchopneumonia, Fatty Liver, Edema of Brain (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mullen M.D. Medical Examiner.
Date signed 10-11-45

X

G33151 BALTIMORE CITY HEALTH DEPARTMENT G33151
Registered No.

CERTIFICATE OF DEATH 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) to
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Sudbrook Lane (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Warren

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John A. Warren
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 4th 1870
8. AGE: Years 75 | Months 8 | Days 5 | If less than one day hr. min.
9. Birthplace England (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wm. Bracken
13. Birthplace England

MOTHER
14. Maiden Name Margaret Dowling
15. Birthplace England

16 (a) Informant Mrs. R. N. English
(b) Address 114 Sudbrook Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

OCT 13 1945 (b) Signed Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1945 to 10/9 1945 and that I last saw h alive on 10/9 1945.

Immediate cause of death Streptococcic Toxemia — Duration (5 days?)
Due to Renal insufficiency (Chronic) — (10 days)
Due to Bronchopneumonia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F. L. Liechti Jr M. D.
Address Bon Secours Hosp. Date signed 10/9/45

PRINCE WHITE FEATHER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33152 G33152 ✓ G33152
481759

BALTIMORE CITY HEALTH DEPARTMENT Registered No. 561

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 S. W 7th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnnie Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Muriel
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) 12-18-04

8. AGE: Years	Months	Days	If less than one day
40	9	25	hr. min.

9. Birthplace Miss.
(Town, county, and state)
10. Usual Occupation Manager
11. Industry or business

FATHER
12. Name Barney Cooper
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Rabach
15. Birthplace Russia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/12/45 (month) (day) (year)
(c) Cemetery or crematory
Location Washington

18 (a) Funeral director B Baumgarten
(b) Address 3501-14th St. N.W. Washington, D.C.

19 (a) Date received by registrar OCT 12 1945 (b) Registrar Huntington Williams

OCT 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 2.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-10 1945 to Oct-12 1945, and that I last saw him alive on Oct-12 1945.

Immediate cause of death	Duration
Brain Tumor	
Due to Cerebral Compression	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/10/45
Major findings of operation: Cerebral meningioma.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Cushing M.D.
Address Johns Hopkins Hosp. Balto. Md.
Date signed 10/12/45

X

G33153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G33153

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Calverton Heights
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 E. 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Smyser

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George F. Smyser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1867

8. AGE: Years 78 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George J. Frederick
13. Birthplace Md.

MOTHER
14. Maiden Name Sevilla Stall
15. Birthplace Md.

16 (a) Informant Mr. Charles F. Smyser
(b) Address 2405 Calverton Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (Date received by registrar) OCT 13 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1945, at 11:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McCullough M.D. Medical Examiner.
Date signed 10/12/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G33154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully (tippe correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLOTTE FRANCES AARON or (Ahrens)

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-12-4909

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1899

8. AGE: Years	Months	Days	If less than one day
46	1	3	hr. min.

9. Birthplace Paris, Mo. (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business Heywood-Wakefield Co.

FATHER
12. Name John Marion Nolen
13. Birthplace Missouri

MOTHER
14. Maiden Name Katherine Johnson
15. Birthplace Missouri

16 (a) Informant Mr. John Donald Ahrens
(b) Address 1810 Ruxton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1945, at 10.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1945, to 10-11 1945 and that I last saw her alive on 10-11 1945.

	Duration
Immediate cause of death Carcinomatosis	1 wk
Due to Metastasis from Papillary Carcinoma of ovary	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Exploratory 10-2-45
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul R. Meyers M. D.
Address Mercy Hospital Date signed 10-11-45

VS 150

X

633155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

633155 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Carolina St.

(c) Hospital or institution: Saint Joseph Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days

(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balto

(c) City or town Balto. 3

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1201 Lakeside Ave. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME MR. FRANK NOVAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife FLORENCE NOVAK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 17-1877

8. AGE: Years	Months	Days	If less than one day
68	6	24	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation REAL ESTATE

11. Industry or business

FATHER 12. Name JOHN B. NOVAK

13. Birthplace CZECHO SLOVAKIA

MOTHER 14. Maiden Name BARBARA DUSEK

15. Birthplace CZECHO SLOVAKIA

16 (a) Informant VICTOR J. GAVIN

(b) Address 2219 KENTUCKY AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)

(c) Cemetery or crematory OAK HILL Bohemian

Location

18 (a) Funeral director Chas J. Eggan Son Inc

(b) Address 1622 Mt. Royal Ave

19 (a) OCT 13 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945, at 12 01 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1945, to Oct. 11, 1945, and that I last saw h[illegible] alive on Oct 11, 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Carcinoma of gall bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M.G. Robertson M. D.

Address St Josephs Hosp Date signed 10-11-45

VS 150

X

G33156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 50-yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Mosher Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: No

6 (b) Name of husband or wife: Bertha B. Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Bertha B. Turner
(b) Address 642 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Gregory
Location Baltimore Co

18 (a) Funeral director Sam'l W. Chase & Son
(b) Address 638 N. Gilmor St

(a) OCT 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1945, at 5:16 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D. Medical Examiner.
Date signed October 12, 1945.

G33157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G33157

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3210 Auchentoroly Ter (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marlene McKenell

3 (b) If veteran, name war W

3 (c) Social Security Account No. [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18. 1945

8. AGE: Years	Months	Days	If less than one day
3 wks		24	hr. min.

9. Birthplace Balt, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name Wm McKenell

13. Birthplace Scotland

MOTHER

14. Maiden Name Agnes Pace

15. Birthplace Pa.

16 (a) Informant Agnes McKenell

(b) Address 3210 Auchentoroly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md

18 (a) Funeral director Milton Sothoron

(b) Address 217 E. Lexington

19 (a) OCT 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1945 to Oct. 12 1945, and that I last saw her alive on Oct. 12 1945.

Immediate cause of death	Duration
Irreversible brain Changes	
Due to Acidosis & Dehydration	
Due to Epidemic Diarrhea of the Newborn.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —

(e) Means of injury —

23. Signature Wm A. Holbrook M. D.

Address Univ. Hosp. Date signed 10-12-45

VS 150

633158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

633158
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3829 Clifton ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Siemers, Helen

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of ~~husband or wife~~ ~~Emerson~~ Harold B. Graf

6 (c) If ~~married~~, ~~widow~~ or ~~widower~~ — years

7. Birth date of deceased (mo., day, yr.) Aug 4. 1894

8. AGE: Years	Months	Days	If less than one day
51	2	8	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sr. Clerk

11. Industry or business —

FATHER
12. Name William Barrett
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name M. Jones
15. Birthplace Virginia

16 (a) Informant Frances V. Siebert
(b) Address 3829 Clifton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 1214 E Fort St

19 OCT 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12-1945, at 5 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 44 to 10-12-1945, and that I last saw her alive on 10-12-1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to —

Due to —

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature H. B. Graf M. D.
Address 7 Franklin Sq Hosp 94a Date signed 10-12-45

G33159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G33159

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Ellen Lee Marks.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife James E. Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12 1867

8. AGE: Years 78 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James H. Corbin
13. Birthplace Va.

MOTHER
14. Maiden Name Ellen Broadwater
15. Birthplace Va.

16 (a) Informant James E. Mark Sr.
(b) Address 2206 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St

19 OCT 13 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 11 1945, and that I last saw her alive on Oct 10 1945.

Immediate cause of death Cerebral thrombosis. — Duration 24 hrs

Due to Cerebral arterio sclerosis — Duration 10 yrs.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. McCarty M. D.

Address 87 W. Preston St Date signed 10/12/45

VS 150

X

633160

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

633160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 WILLIAM ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 WILLIAM ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BRIDGET REED

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	WHITE	WIDOW

6 (b) Name of husband or wife CHARLES H REED
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) NOV 11-1878

8. AGE: Years	Months	Days	If less than one day
66	11	0	hr. min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME.

FATHER
12. Name MICHAEL McNAMEE
13. Birthplace IRELAND

MOTHER
14. Maiden Name ANNIE GALLAGHER
15. Birthplace IRELAND

16 (a) Informant MRS JOHN JENKINS
(b) Address IRELAND.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 16-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS CEM
Location A A Co. MD

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E West St

19 (a) OCT 13 1945 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct. 11 1945 and that I last saw h alive on 19.

Immediate cause of death
Coronary heart disease — Duration 1 day
Due to
Due to Chronic myocarditis — 5 yrs
Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 125 S Clarke St Date signed

X 10/12/45

G33161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 D

Registered No. G33161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore #17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Penna. Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Alverta Robertson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/05

8. AGE: Years	Months	Days	If less than one day
40	7	8	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business —

FATHER
12. Name John Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Alverta Reed
15. Birthplace Virginia

16 (a) Informant Records
(b) Address

17 (a) Burial (b) Date thereof Oct 15-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

OCT 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1945 at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/31 1945 to 10/10 1945 and that I last saw her alive on 10/10 1945.

Immediate cause of death Carcinomatosis

Due to Carcinoma of rectum sigmoid

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

Duration
?
2 mos. +

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Alex C. Tilley Jr M. D.
Address Mercy Hosp. Date signed 10/10

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

633162 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Madison Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Phipps

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Crawley Cousin
(b) Address 704 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolph Halstead
(b) Address 918 Bartid Hill Ave.

19 (a) (Date rec'd by registrar) OCT 13 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 45 19, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Macneis M.D.
Medical Examiner.
Date signed October 10, 1945.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33163 ✓ G33163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Eislen
(b) Street address 412 ~~Dueland~~ St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 412 ~~Dueland~~ St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James H. Bowser
3 (b) If veteran, name war
3 (c) Social Security Account No. 220-05-3268

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jul. 4, 1881

8. AGE: Years	Months	Days	If less than one day
64	3	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name James H. Bowser
13. Birthplace Md.

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Rosa Bowser
(b) Address 927 Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945, at 5 05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1945 to Oct 11 1945 and that I last saw h/s alive on Oct 9 1945.

Immediate cause of death
Generalized Arteriosclerosis
Due to
Due to Chronic Nephritis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. H. Bowser M. D.
Address 844 S. Carey St
Date signed 10/12/45 M. D.

X

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

633164 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division St

(c) Hospital or institution: Provident Hospital 23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1009 Peach alley (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Gladys Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Negro	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-1911

8. AGE: Years	Months	Days	If less than one day
34	3	5	hr. min.

9. Birthplace Hopewell, Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Andrew Jenkins

13. Birthplace Virginia

MOTHER

14. Maiden Name Gertrude Washington

15. Birthplace Virginia

16 (a) Informant William James

(b) Address 630 Haw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Bunid Hill Ave.

OCT 13 1945 (Date rec'd by registrar)

(c) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1945 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1945 to 10-9 1945 and that I last saw her alive on 10-9 1945.

Immediate cause of death Lung abscess — Duration 4 weeks

Due to Pneumonia

Due to

Other Conditions — Duration over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James D. Carr M. D.

Address 5 E Mosher St Date signed 10-12-45

VS 150

8

X

633165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 633165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Kinsey Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Kinsey Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Manser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry B. Manser
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Oct 1, 1868
8. AGE: Years 77 | Months 0 | Days 10 | If less than one day: hr. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Lillian M. Abey
(b) Address: 2803 Kinsey Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 15, 1945 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: City

18 (a) Funeral director: Mr. Mrs. John W. Teufel & Son
(b) Address: 801 W. Fayette St.

19 (a) OCT 12 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11 1945 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1925 to Oct 11 1945 and that I last saw h[illegible] alive on Oct 11 1945

Immediate cause of death: Hypostatic Pneumonia — Duration: 48 hrs
Due to, Myocarditis — 1 yrs
Due to Arteriosclerosis — 20 yrs
Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)
Date of operation: ✓
Major findings of operation: ✓
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Howard Kalm, M.D.
Address: 1027 N. Wolfe St. Date signed: 10/11/45

FORMS WARD KEELING, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Washington Williams 11th

929

G33166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G33166
Registered No.

PRINT NAME, PLACE, AND DATE CLEARLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hos.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Fleet St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Catherine Myszkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Stanislaus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years about 55 | Months | Days | If less than one day hr. min.

9. Birthplace Poto Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Anthony
13. Birthplace Poland

MOTHER 14. Maiden Name Rosalia Bryczkowski
15. Birthplace Poland

16 (a) Informant Stanislaus Myszkowski
(b) Address 2539 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. Md.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Date received by registrar OCT 13 1945 (b) Registrar Huntington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1945, to 10-12 1945, and that I last saw h~~er~~ alive on 10-12 1945.

	Duration
Immediate cause of death Carcinoma of body of Pancreas	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Hayden M.D.
Address Bon Secours Date signed 10-13-1945

VS 150

X

633167 Square #16 (OVER) 633167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Bolton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Klug

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John G. Klug

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1867

8. AGE: Years	Months	Days	If less than one day
77	11	14	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Russell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Elliott
15. Birthplace Balto. Md.

16 (a) Informant H. J. Maldeis, M.D.
(b) Address Chief Med. Exam.

17 (a) Burial (b) Date thereof 10/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location PUBLIC CEMETERY OCT 9 1945

18 (a) Funeral director HENRY SANDERS & SON, 8[illegible]
(b) Address NORTH [illegible] AVENUE

19 OCT 12 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1945, at 5[illegible] M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Faulkner M.D.
Medical Examiner.
Date signed Sept. 26 1945

VS 151 (OVER)

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G33168 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3021 Overland a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3021 Overland a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward W. Brooks.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gillian M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4. 1869

8. AGE: Years 76 | Months 2 | Days 6 | If less than one day: hr. min.

9. Birthplace England (town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edward Brooks
13. Birthplace England.

MOTHER
14. Maiden name Caroline Woolloen
15. Birthplace England.

16 (a) Informant Gillian M. Brooks.
(b) Address 3021 Overland. av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13. 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Mem.
Location Taylor. av

18 (a) Funeral director John A. Hoffman
(b) Address 3600 E. Baltimore, St

19 (a) (Date received by Registrar) (b) Huntington Williams, Registrar

OCT 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10- 1945, at 10 39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Oct 10 1945, and that I last saw him alive on Oct 9 1945.

Immediate cause of death: Chronic myocarditis — Duration: 3 years
Due to —
Due to —
Other Conditions: Senyl Arteriosclerosis — 8 years
(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Not
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None

23. Signature L. K. Gayley M.D.
Address 5106 Harford Rd Date signed 10/11/45

X

G33169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G33169
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3125 Pelham Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Poyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 21, 1896

8. AGE: Years	Months	Days	If less than one day
49 yrs.	8	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Stransky
13. Birthplace Czech.

MOTHER
14. Maiden Name Mary Metejka
15. Birthplace Czech.

16 (a) Informant Albert Poyer (husband)
(b) Address 3125 Pelham Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Road. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) Date received by Registrar OCT 13 1945 (b) Huntington Mathias, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945, at 3.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Oct. 12 1945, and that I last saw h alive on Oct 11 1945

Immediate cause of death acute myocardial insufficiency — Duration 2 days.
Due to carcinomatosis — ?
Due to adeno-carcinoma of left breast
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. C Schimunek M. D.
Address 447 N. Kenwood Ave. Date signed 10/13/45

433170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

Registered No. 6330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louisa Grill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1887

8. AGE: Years	Months	Days	If less than one day
58 yrs.	8	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Fairfield

FATHER
12. Name Ludwig Grill
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Fuchs
15. Birthplace Germany

16 (a) Informant Theresa A. Washey (sister)
(b) Address 916 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Holy Redeemer
Location Belair Rod. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Washington

19 (a) OCT 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1945, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1945, to 10-11 1945, and that I last saw him alive on 10-11 1945.

Immediate cause of death	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-27-45

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. E. Wolfe M. D.
Address 1400 N. Caroline St Date signed 10-11-45

VS 190

G33171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G33171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 27-18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3324 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Flora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1878

8. AGE: Years 67 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Ruusia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Solomon Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Ruusia

16 (a) Informant Samuel Cohen
(b) Address 3324 W Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by reg.) OCT 13 1945 (b) Registrar's signature Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 19 45 at 1110 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1945, to 10-12 1945 and that I last saw him alive on 10-9 1945.

Immediate cause of death	Duration
Uremia & cachexia	
Due to Chronic nephritis &	
Due to Cancer of stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram J. Ruslander M. D.
Address Sinai Hosp Date signed 10-13-45

X

G33172

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G33172 / 486

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wilkins Ave & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 24 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2109 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Anna Velinsky

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan, 10, 1895

8. AGE: Years: 50 | Months: 9 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: House Work

FATHER
12. Name: Benjamin Fox
13. Birthplace: Russia

MOTHER
14. Maiden Name: Mary Friedman
15. Birthplace: Russia

16 (a) Informant: Mrs Rena Roth
(b) Address: 3700 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct, 14, 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Philadelphia Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date received by registrar) (b) Registrar

OCT 13 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 12 1945, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1945, to Oct 12 1945; and that I last saw h. alive on Oct 12 1945

Immediate cause of death: Acute Cardio-Respiratory failure

Due to: Generalized Carcinomatosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Cirthus T. Hall Jr. M. D.

Address: St. Agnes Hosp. Date signed: 11/12/45

X

633173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No. 633173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 n. Calhoun st
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 n. Calhoun st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanch Shaw

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	widowed

6 (b) Name of husband or wife William Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1883

8. AGE: Years	Months	Days	If less than one day
62	4	9	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant James Shaw
(b) Address 1734 n. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-43 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. G. Nelson
(b) Address 1343 Pennsylvania Ave

OCT 13 1943 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1943, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1943, to Oct. 10 1943, and that I last saw h[illegible] alive on Oct. 10 1943.

Immediate cause of death: Acute Myocarditis
Due to: Uremia
Due to: Chr. Nephritis
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 1 Day, 2 Days, 3 mos.

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lee Berry M. D.
Address 420 E. Chase Date signed 10-12-43

VS 150

Supt.—1-10-21—M&T—1500 Blks.

G33174 HEALTH DEPARTMENT—CITY OF BALTIMORE G33174

CERTIFICATE OF DEATH. 939

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie S. Wherrett Wherrett.

(a) RESIDENCE No. 4013 Liberty Heights Ave ST., 15-10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William G Wherrett

6 DATE OF BIRTH (month, day, and year) Aug 20 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	76	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Saint Amboy N J

PARENTS

10 NAME OF FATHER Richard C Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) N J

12 MAIDEN NAME OF MOTHER Mary E Potter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N J.

14 Informant W Norman Wherrett

(Address) 2920 Harrison St Huntington

15 Filed OCT 13 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11th 1945

17 I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1945, to Oct 11th, 1945, that I last saw h.... alive on Oct 10th, 1945, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & arteriosclerosis Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J A Boulton, M. D.

Oct 11, 1945 (Address) 3904 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Oct 15 1945
20 UNDERTAKER Ullrich Funeral Home	ADDRESS 2008 Edmondson Ave

TION is very important. See instructions on back of certificates.

633175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 633175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT BARKLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Margaret M. Barkley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1857

8. AGE: Years	Months	Days	If less than one day
88	6	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Barkley
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Hughes
15. Birthplace Md.

16 (a) Informant Miss Margaret Barkley, daughter
(b) Address 3808 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

CT (a) 13 1945 (Registered by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1945 at 8:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945 to Oct 11 1945 and that I last saw h[illegible] alive on Oct 10 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 Hrs
Due to
Due to
Other Conditions Hypertensive Cardiovascular Renal Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Daly M.D.
Address 817 Medical Arts Bldg. Date signed Oct 13 45

VS 180

633176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 633176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 John Street
(c) Hospital or institution:
14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE GEDDES DONNELLY

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: William Charles Donnelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1857

8. AGE: Years 88 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name - Geddes
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. William C. Donnelly
(b) Address 1617 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) OCT 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945 at 6:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Oct 11 1945; that I last saw him alive on Oct 11 1945

Immediate cause of death: Chronic Myocarditis Hypostasis

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Operation: Yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Hoard

Address 1925 W Mount Rd Date signed 10-13-45

VS 180

G33177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G33177 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 N. Fulton Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) abt. 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Herbert Evans

3 (b) If veteran, name war ~~World War I~~
3 (c) Social Security Account No. None (?)

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith V. Evans
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) Aug. 30 1901

8. AGE: Years	Months	Days	If less than one day
44	1	11	hr. min.

9. Birthplace Springfield Illinois (Town, county, and state)
10. Usual Occupation Supt. of Production
11. Industry or business Govt. Army

FATHER
12. Name Thomas Evans
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Unknown

16 (a) Informant Mrs. Edith V. T. Evans (wife)
(b) Address 30 N. Fulton Ave - City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave - Balto. City

18 (a) Funeral director Stewart & Moulden Company
(b) Address 108 W. North Ave, Balto, Md

19 OCT 13 1945 (b) (Date rec'd by registrar) Registrar

Huntington Woods Mich

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1945, at 4:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945, to Oct 11 1945, and that I last saw him alive on Oct 11 1945.

Immediate cause of death	Duration
Cerebral thrombosis	1 day
Due to Generalized atherosclerosis	?
Due to with hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 N. Fulton Ave Date signed 10/12/45

VS 150

G33178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G33178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 M
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Brooklyn
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Brooklyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Harry Cairns

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-14-9147

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1870

8. AGE: Years	Months	Days	If less than one day
75	1	18	hr. min.

9. Birthplace Pennsylvania (Town, County, and state)
10. Usual Occupation Janitor
11. Industry or business Unemployed

FATHER
12. Name John
13. Birthplace Penn

MOTHER
14. Maiden Name Mary
15. Birthplace Penn

16 (a) Informant Son Leroy
(b) Address 3119 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director John F. Dennis & Son
(b) Address 713 Light St.

19 (a) Date received OCT 19 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1945 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945 to 10/11 1945 and that I last saw h. alive on 10/11 1945.

Immediate cause of death Pneumonia Lobar

Due to Pneumonia / Cirrhosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Delaney Dedomenico M. D.
Address Date signed

VS 150

X

GRIM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633179 / 94a

633179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mitchell & Catonsville Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 90 & Frederick Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Catherine Grim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick C. Grim

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-1888

8. AGE: Years 57 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George L. Ball
13. Birthplace Prince George Co. Md.

MOTHER
14. Maiden Name Rebecca Umbaugh
15. Birthplace Howard Co. Md

16 (a) Informant Frederick C. Grim
(b) Address 908 Frederick Ave Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Easton Sons
(b) Address 608 N Frederick Ave Catonsville Md

OCT 13 1945
(Date rec'd by registrar)

(b) Signature of registrar Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/ 1945 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/ 1945 to 10/12/ 1945 and that I last saw h[illegible] alive on 10/11/ 1945

Immediate cause of death	Duration
Cardiac failure due to Coronary Sclerosis	
Due to Pneumonia and Bronchitis	
Due to	
Other Conditions Obesity - Viral Pneumonia Pa Bone	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Cliff Routh Jr. M. D.
Address St. Agnes Hosp Date signed 10/12/45

VS 150

633150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 633150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Joseph

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1904

8. AGE: Years	Months	Days	If less than one day
40	10	29	hr. min.

9. Birthplace Nottaway County Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Ford
13. Birthplace Va.

MOTHER
14. Maiden Name Jennie Fowlkes
15. Birthplace Va.

16 (a) Informant Josephine Scott
(b) Address 1402 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County Md.

18 (a) Funeral director Mrs. Robert O. Elliott Dept
(b) Address 1129 N. Caroline Street

19 (b) OCT 13 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10 1945, at 10.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardia-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 10/11/45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Saint Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Fullerton (If outside city or town limits, write RURAL and give town)
(d) Street No. Forge Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ESTELLA DOWNEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	NEGRO	Separated

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1915

8. AGE: Years	Months	Days	If less than one day
30	1	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Carroll Myers

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Brown

15. Birthplace Md.

16 (a) Informant Marcella Haynes

(b) Address Bradshaw Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 '45 (month) (day) (year)

(c) Cemetery or crematory Asbury Cemetery

Location Parkville Md.

18 (a) Funeral director Wm. Roberts Elliott & Bro.

(b) Address 1129 N. Caroline St.

19 (a) OCT 12 1945 (Date rec'd by Registrar) (b) Huntington Wilson, Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945, at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10, 1945 to Oct. 11 1945, and that I last saw h[illegible] alive on Oct. 11, 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive cardio vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd Jr. M.D.

Address St Joseph's Hosp Date signed 10/11/45

X

633182
481294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

633182
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTED WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Mount Pleasant Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Doran

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-06-5726

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Ingrid.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-03

8. AGE: Years	Months	Days	If less than one day
42.	6	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Office's. Maid Electric
11. Industry or business

FATHER
12. Name John Doran
13. Birthplace md.

MOTHER
14. Maiden Name Catherine G. Geyer
15. Birthplace Md.

16 (a) Informant Ravenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem. Pk.
Location Baltimore

18 (a) Funeral director Philip Hering Sons
(b) Address 2624 Elleans St

19 (a) OCT 13 1945 (Date received by Registrar) (b) Hunting for Wilbur Burial Permit No.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct-11-1945 at 7.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-1-1945 to Oct-11 1945 and that I last saw him alive on Oct 11 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic heart disease, mitral	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Vance
Address Johns Hopkins Hosp. Date signed 10/13/45

633183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. 633183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 Maryddell Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 319 Maryddell Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Marie Limon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1893

8. AGE: Years 51 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace New Orleans La (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Robert Massel

13. Birthplace La

MOTHER 14. Maiden Name Zora Hummers

15. Birthplace N Y

16 (a) Informant Joseph B Limon

(b) Address 319 Maryddell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (Month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore Md

18 (a) Funeral director Geo L Fayle

(b) Address Fulton Ave & Fayette St

19 (a) Date received OCT 14 1945 (b) Registered by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1945 at 11 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to Oct. 11 1945 and that I last saw h alive on Oct. 10 1945.

Immediate cause of death	Duration
Carcinomatosis Generalized	
Primary Adenocarcinoma Uterus	
Due to (a) (cervix)	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas B. Shanley M. D.

Address 545 Fulton Ave. Date signed 10-13-45

X

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

633184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a 633184 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2890 Kentucky avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2890 Kentucky avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LEO J. McCARTHY

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-01-3927

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Catherine R. McCarthy
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	19	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Storekeeper
11. Industry or business

FATHER
12. Name Joseph J. McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name Rosa Dennistone
15. Birthplace New York

16 (a) Informant Mrs. Catherine R. McCarthy
(b) Address 2890 Kentucky avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Chas J. Evans Sons Inc
(b) Address 118 W. Mt Royal Ave
(c) 10-14-1945 (Date filed by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Oct 12 1945, and that I last saw him alive on Oct 11 1945.

Immediate cause of death	Duration
Bronchial Pneumonia	1 wk
Due to	
Due to	
Other Conditions Coronary Disease	6 mo

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz J Krueger M.D.
Address 2700 Harford road Date signed 10-12-45

VS 280

X

G33185 ✓G33185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Rudasill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Jefferson Rudasill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1872

8. AGE: Years	Months	Days	If less than one day
72	9	17	hr. min.

9. Birthplace Wilson, N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Edgar Rudasill.
(b) Address 1503 W. Saratoga St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10 14 '45 (month) (day) (year)

(c) Cemetery or crematory
Location Wilson, N. C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

OCT 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 19 45 to 10/12 19 45, and that I last saw h. alive on 10/12 19 45

Immediate cause of death

Due to Coronary Occlusion
Due to Coronary Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Rudasill M.D.
Address 416 N. Johns St. Date signed 10/13/45

X

G33186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G33186
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1275 Calverton Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1275 Calverton Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Elizabeth Birt

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry Birt
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 7, 1885

8. AGE: Years	Months	Days	If less than one day
60	2	5	hr. min.

9. Birthplace Braddock Heights, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Adam Bible
13. Birthplace Maryland.

MOTHER
14. Maiden Name Julia Brain
15. Birthplace Maryland

16 (a) Informant Henry Birt
(b) Address 1275 S. Calverton Road

17 (a) Burial (b) Date thereof 10-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evangelical Lutheran
Location Middletown, Maryland

18 (a) Funeral director George L. Schnauf
(b) Address 2101 Frederick Avenue

19 (a) Filed 10-14-1945 (b)
(Date filed by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 10/12 1945, and that I last saw h alive on 10/11 1945.

Immediate cause of death	Duration
Hypertensive heart disease	1 yr
Due to	
Due to	
Other Conditions Cerebral hemorrhage	1 day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD M. D.
Address 2020 Wilkens Date signed 10/13/45

X

HEP #96487 633187 BALTIMORE CITY HEALTH DEPARTMENT G33182 Registered No.

CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married (Separated)

6 (b) Name of husband or wife Virginia Carter
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 6/18/1910

8. AGE: Years	Months	Days	If less than one day
35	3	28	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Harriett Taylor (d)
15. Birthplace Virginia

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory Kimmandhan
Location

18 (a) Funeral director Geo. G. Nelson
Address 1303 Eastern Ave

19 (a) OCT 14 1945 (Date rec'd by registrar) (b) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12th 1945, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1945 to Oct. 12, 1945, and that I last saw him alive on Oct. 12, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams D. Kalat M. D.
Address 4940 Eastern Ave Date signed 10-13-45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied. The

G33188

BALTIMORE CITY HEALTH DEPARTMENT G33188

CERTIFICATE OF DEATH 46F

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette st
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore And
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5102 Ardmore Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Reuben G. Bowden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Hall Bowden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10th 1914

8. AGE: Years	Months	Days	If less than one day
31	9	1	hr. min.

9. Birthplace Giles W. Va
(Town, county, and state)
10. Usual Occupation Forman Mutual Chem. Co.
11. Industry or business Chemical Co.

FATHER
12. Name Giles Bowden
13. Birthplace W. Va.

MOTHER
14. Maiden Name Bessie Voght
15. Birthplace W. Va.

16 (a) Informant Wife, Mary Bowden
(b) Address 5102 ardmore Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore st

19 (a) 1945 (b) Huntington Williams, Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1945, at 11 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1945 to 10-11 1945, and that I last saw h. alive on 10-11 1945.

Immediate cause of death Primary Carcinoma of Liver

Duration
1 yr.

Due to

Due to

Other Conditions Metastasis to Lungs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Dx of Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 10-12-45

VS 150

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Do not abbreviate, use ditto marks, or leave blanks. Answer all questions.

633189 ✓ 633189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2647 Wilkins Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 Wilkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Moran

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie B. Moran

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 7-1869

8. AGE: Years 76 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace West Va (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B&O. R.R.

FATHER 12. Name Cornelius Moran

13. Birthplace Ireland

MOTHER 14. Maiden Name ?

15. Birthplace Ireland

16 (a) Informant Lillie B. Moran

(b) Address 2647 Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Loth Cr B & M-Walbrook City

18 (a) Funeral director

(b) Address 2101 Stricker St

19 (a) (Date rec'd by local registrar) (b) OCT 14 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1945 at 12 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Oct 11 1945 and that I last saw him alive on Sept 10 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Hemiplegia

Due to Hypertension Nephritis

Due to Arteriosclerosis.

Other Conditions Pulmonary Abscess

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Nitsch M. D.

Address 2351 Westwood Ave Date signed 10/12/45

G33190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G33190

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Spanham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (Route #7)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route # 7
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Patricia Stambaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1941

8. AGE: Years	Months	Days	If less than one day
4	2	3	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Elmer Stambaugh
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Elizabeth Delander
15. Birthplace West Virginia

16 (a) Informant Mother
(b) Address Route 7 Westminster

17 (a) Burial (b) Date thereof Oct 15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lucken Cemetery
Location Uniontown Md

18 (a) Funeral director Raymond K. Knight
(b) Address Union Bridge Md

19 (a) 1945 (b) Huntington Williams Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1945, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945 to Oct 13 1945, and that I last saw h.s.r. alive on Oct 13 1945.

Immediate cause of death	Duration
Diphtheritis myocarditis	4 days
Due to Apathenia	13 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Spanham Hospital Date signed 10/13/45

VS 3

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33191
Registered No.

1. PLACE OF DEATH: Ship docked at
(a) Baltimore City, Maryland
(b) Street address Port Covington
(c) Hospital or institution:
On Ship - Board Rio Jackal
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Buenos Aires Argentina
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Echeverria Street
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Argentina

3 (a) FULL NAME Jose Jelicovitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Samuel Jelich
(b) Address Malden Mass

17 (a) Removal (b) Date thereof 10-17-43
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location BUENOS AIRES - ARGENTINA

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

(a) OCT 14 1943 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1943, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed October 12, 1943.

VS 151

G33192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G33192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MT SINAI Home
461308 Usave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4019 Norfolk ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Re Shafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Australia (Town, county, and state)

10. Usual Occupation: House wife

11. Industry or business

FATHER
12. Name: Abraham
13. Birthplace: Pozen

MOTHER
14. Maiden Name: Sarah
15. Birthplace: Pozen

16 (a) Informant: Herbert Shafer
(b) Address 4019 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory: Meadowview Memorial Park
Location: Montgomery Co

18 (a) Funeral director: Jack Lewis Inc
(b) Address 409 E Balto St

19 (a) 1945 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1945, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945, to 10/12 1945, and that I last saw her alive on OCT 12 1945.

Immediate cause of death: Arteriosclerotic CV disease — Duration: Few years

Due to: Senile dementia — 2 years

Due to: Marasmus — few mos

Other Conditions: Acute Gastro Enteritis — 1 week

Terminal Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Alex A Weinstock M. D.

Address 4603 Park Ave Date signed 10/12/45

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

633193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

633193 ✓ 476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 2812 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Davidman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day hr.	min.
70				

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Reverend

11. Industry or business

FATHER
12. Name Solomon
13. Birthplace Austria.

MOTHER
14. Maiden Name Marietta
15. Birthplace Austria

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Belair Rd.

18 (a) Funeral director Jack Levin Lyn
(b) Address 1432 E Balto St.

19 (a) — 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945, at 8 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1945 to Oct 12 1945, and that I last saw h[illegible] alive on Oct 12 1945.

Immediate cause of death Tracheal obstruction (Tumor) — Duration

Due to Diabetes mellitus — Duration

Due to Arteriosclerotic Heart Disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arnold Ostry M.D.
Address Sinai Hospital Balto Md Date signed 10-13-45

VS 189

G33194 G33194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4119 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4119 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Greenberg

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1874 (1870)

8. AGE: Years	Months	Days	If less than one day
71 (65)			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Simeo
13. Birthplace Russia

MOTHER
14. Maiden Name Ewing
15. Birthplace Russia

16 (a) Informant Mrs Sam Barr
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory Levy Chevra
Location Wash. Blvd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

10-14-1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 12 1945 and that I last saw h[illegible] alive on Oct 1, 1945

Immediate cause of death	Duration
Carcinoma of the Colon	1 year
Due to Obstruction	1 mo
Due to	
Other Conditions Senile Anemia	6 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Alex Abramowitz M.D.
Address 4603 Park Heights Ave Date signed 10/15/45

VS 150

633195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

633195 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 321 W. Allendale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and name county)
(d) Street No. 321 W. Allendale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Freedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. Adolph H. Freedman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name — Wenkranth
13. Birthplace Russia

MOTHER
14. Maiden Name Rhebe —
15. Birthplace Russia

16 (a) Informant Mr. Adolph H. Freedman
(b) Address 321 W. Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) 1945 (Date rec'd by registrar) (b) Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-45 19 , at 9.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942, to 10/11 1945.
and that I last saw h[illegible] alive on 10/10 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Hypertensive cardio vascular renal disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leon Freedman M. D.
Address 1031 St Paul St. Date signed 10/12/45.

G33196

BALTIMORE CITY HEALTH DEPARTMENT G33196 Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3928 Fernhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15"
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Asher B. Bettigole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs. Kitty Kerr
(b) Address 3928 Fernhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jos. Lewis Inc
(b) Address 1739 E. Balto. St

19 1945 (Date rec'd by registrar) Huntington Williams, Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13-45 19 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/5 1945 to 10/12 1945 and that I last saw h[illegible] alive on 10/12 1945.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Ch Myocarditis	
Due to Ch arterio sclerosis	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asher Bettigole M. D.
Address 133 Augusta Dr Date signed 10/13/45

VS 150

X

G33197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G33197 Registered No.

PRINT WITH PENCIL, WITH CARBONING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Walbrook Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Walbrook Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Henry Baker

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Josephine Baker
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23-1864

8. AGE: Years	Months	Days	If less than one day
81	4	19	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business B. & O. R.R.

FATHER
12. Name Henry Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Kraft
15. Birthplace Germany

16 (a) Informant Mrs Nan L. Baker
(b) Address 6610 Greenwich Ave Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md

18 (a) Funeral director J. B. Mayfield Son
(b) Address 1300 Eutaw Place

19 (a) OCT 14 1945 (Date received by registrar) (b) Huntington Williams Registrar

OCT 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1945, to 10/12 1945, and that I last saw h— alive on 10/12 1945

Immediate cause of death Bronchopneumonia — Duration

Due to —

Due to —

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Aloha H. Lemmon M.D.
Address 4709 Hurd Ave Date signed 10/14/45

X

G33198

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G33198 Registered No. 1498

PRINT WITH TYPEWRITER OR INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E. Eutaw St.
(c) Hospital or institution Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1910 E. Lanvale St (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Betty Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-2445

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William L. Harrison

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) June 6 - 1924

8. AGE: Years 27 | Months 4 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John H. White
13. Birthplace Chester Co. Penn.

MOTHER
14. Maiden Name Mary E. Collier
15. Birthplace Penn

16 (a) Informant John H. White Jr.
(b) Address 2025 E. Eutaw St. Baltimore Md

17 (a) Disposition (Burial, cremation, or removal) Date thereof 10/14/45 (month) (day) (year)
(c) Cemetery or crematory Stevensville Md
Location Queenstown

18 (a) Funeral director L. S. Whitehead Funeral Home
(b) Address Easton Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-45 19 , at 10:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 1945 to Oct 11th 1945; that I last saw h[illegible] alive on Oct 11th 1945

Immediate cause of death: Post Partum Shock. — Duration: 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Calas, M.D.
Address 47 N. Dalton Date signed 10/10/45

VS 150

[redacted] G33199 BALTIMORE CITY HEALTH DEPARTMENT [redacted] Registered No. G33199

CERTIFICATE OF DEATH 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Kingsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Franklinville Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Domonic (Joshua) Hammond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	4	14	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Joshua Hammond
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Augusta Ledley
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. Frank Hammond
(b) Address Upper Falls, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Salem Methodist
Location Upper Falls, Md.

18 (a) Funeral director Lemmon Funeral Home
(b) Address 7401 Belair Road

19 (a) OCT 14 1945 (Date filed by registrar) Everington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945, at 2:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Subdural Hemorrhage.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-2-45 at M.
(b) Where did injury occur? Kingsville, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision of horse and buggy and auto.

23. Signature Benedict Shiteselic M.D. Medical Examiner
Date signed Oct. 14, 1945 per Robert Lee Fenton M.D.

G33200 G33200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 Schuck St.
(If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Rita Fischetta (RITA FISCHETTI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife Dominico Fischetti
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1945

8. AGE: Years	Months	Days	If less than one day
	5 mo	22	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Dominico Fischetti
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Mary Ashley
15. Birthplace Balt. Md.

16 (a) Informant Dominico Fischetti (Father)
(b) Address 3317 Schuck St.

17 (a) BURIAL (b) Date thereof 10-15-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto Dundalk Ave.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) 10-14-1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/45 19 , at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1945, to 10/13 1945, and that I last saw her alive on 10/12 1945.

Immediate cause of death Intestinal Fallamy diarrhea — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. J. Bailey M. D.
Address Mercy Date signed 10/13/45

VS 150

If the above information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633401

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

633401 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Denmead Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) 79

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Denmead (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Sarah Agnes Danninger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow.

6 (b) Name of husband or wife Daniel Danninger | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1866

8. AGE: Years 79 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Timothy Donovan
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Roantry
15. Birthplace Not Known

16 (a) Informant Mrs. M. Danninger
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director J. Walter Stansbury
(b) Address 124 N. Eutaw St

19 (a) 10 4 1945 (Date filed by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1945, at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to 10/11 1945.
and that I last saw h[illegible] alive on 10/10 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days

Due to: Hypertensive & Arterio Sclerotic C.V. Disease — 5 yrs +

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E Roach M.D.
Address 3629 Edmondson Date signed 10/12/45

VS 180

× Roach

G33202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33202 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 S. Eden St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31
(e) Length of stay in Baltimore (yrs., mos., or days) 36

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 400 S. Eden St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Giovanni Giordano

3 (b) If veteran, name war no.

3 (c) Social Security Account No. none.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Asunta Giordano

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) May 23 1873

8. AGE Years 73 | Months 4. | Days 19 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Self.

FATHER 12. Name Samuel Giordano

13. Birthplace Italy

MOTHER 14. Maiden Name Asunta Colucchera

15. Birthplace Italy

16 (a) Informant Frank Profaizer

(b) Address 400 S. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15. 1937 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Location Belair Road

18 (a) Funeral director Wendell Luppert

(b) Address 312 S. Highland Ave

19 (a) Oct 14 1937 (Date received by registrar) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1937 at 1.15 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from June 15 to Oct 11 1937. and that I last saw HIM alive on Oct. 11 1937

Immediate cause of death Cerebral Hemorrhage. Duration 3 YRS.

Due to C.H.C.V.D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) While at work?
(e) Means of injury

23. Signature Chas. Henry Taylor M.D.

Address 5217 York Rd. Date signed Oct 14 1937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33203 BALTIMORE CITY HEALTH DEPARTMENT ✓ G33203

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Arro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Margaret Rulli (Daughter)
(b) Address 625 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Ce.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (Date received by registrar) 1945 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1945, at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W. B. Mitchell M.D. Medical Examiner.

Date signed 10/8/45

G33c04

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G33c04 Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Saint Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 N. Broadway (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME THOMAS A. SCARANTINO

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7195

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband ~~or wife~~ Lina Scarantino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13 1872

8. AGE: Years	Months	Days	If less than one day
73	8	29	hr. min.

9. Birthplace Villarosa Italy (Town, county, and state)
10. Usual Occupation Stone mason
11. Industry or business

FATHER
12. Name Michele Scarantino
13. Birthplace Italy

MOTHER
14. Maiden Name Teresa Scavone
15. Birthplace Italy

16 (a) Informant Lina Scarantino (Wife)
(b) Address 1436 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) Oct 16 1945 (Filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1945, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1945, to Oct. 12 1945, and that I last saw h alive on Oct. 12, 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to dehydration & toxaemia	
Due to Carcinoma of oesophagus.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Riley
Address 1408 N Caroline St. Date signed 10-13-45

VS-180

X

633205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. 633205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EDNA LIZER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William Lizer
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 7, 1886

8. AGE: Years	Months	Days	If less than one day
59	6	7	____ hr. ____ min.

9. Birthplace Hagerstown Washington Co. Md.
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Troninger TROVINGER
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Hartman
15. Birthplace Maryland

16 (a) Informant William Lizer
(b) Address Hagerstown Md

17 (a) Burial (b) Date thereof 10/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rest Haven Cem
Location Hagerstown Md

18 (a) Funeral director H. K. Hoffman
(b) Address Hagerstown Md.

OCT 14 1945
(Date rec'd by registrar) Funeral for William Lizer

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/45 1945 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1945 to Oct 14 1945 and that I last saw her alive on Oct 14 1945.

Immediate cause of death	Duration
Myocardial insufficiency + cardiac arrest	
Due to R. Rheumatic Heart Disease	48 years
Aortic stenosis + insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest M. Larmore, M. D.
Address Church Home & Hospital Date signed 10/14/45

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

LARMORE

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G33x06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

Registered No. G33x06

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 4 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Beall

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1877

8. AGE: Years	Months	Days	If less than one day
68	7	10	hr. min.

9. Birthplace Frederick Md. (Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Dorothy Poole
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Rider's Cem.
Location Westminster, Md

18 (a) Funeral director Francis Pearre
(b) Address Westminster, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1945 to 10/14 1945, and that I last saw him alive on 10/14 1945

Immediate cause of death (a) Cardiac Tamponade (b) Left Hemothorax — Duration 1/4 hrs

Due to Fracture 3, 4, 5, 6 left ribs + laceration of lung from stump — 44 hrs.

Due to Run over by tractor

Other Conditions Left Inguinal hernia, Diabetes mellitus — 3 years
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10/14/45 at ? P.M.
(c) Where did injury occur? Westminster Carroll Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Farm While at work? Yes
(Specify type of place)
(e) Means of injury Run over by Tractor
23. Signature Leonard G. Rowland M.D.
Address University Hospital Date signed 10/17/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-07

480431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63D

Registered No. 633-07

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-16

8. AGE: Years	Months	Days	If less than one day
29	2	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Stock Girl
11. Industry or business

FATHER
12. Name Samuel Watson
13. Birthplace Md

MOTHER
14. Maiden Name Myrtle Matheus
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Sara A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) OCT 14 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 6.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Oct. 12 1945 and that I last saw h[illegible] alive on Oct. 12 1945.

Immediate cause of death	Duration
Asphyxia	
Due to Post operative	
Due to Neonatage	
Hypoidectomy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation October 11, 1945

Major findings of operation: Hyperplasia of Thyroid

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Cooley M. D.
Address John Hopkins Hospital 10-17-45

VS 150

633-08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 633-08

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Riggs Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-1-76

8. AGE: Years 69 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John T. Diggs
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Jones
15. Birthplace Md

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Jas. A. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1945 to Oct. 12 1945, and that I last saw her alive on Oct. 12 1945.

Immediate cause of death: Possible myocardial infarction — Duration: Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maxwell Williams, M.D.
Address John Hopkins Hosp. Date signed 12 Oct 45

VS 150

633x09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. 633x09

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Puget St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Puget St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Healey Sickles

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-0247

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1888

8. AGE: Years 56 | Months 10 | Days 3 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name William H. Sickles
13. Birthplace Anne Arundel Co. Md

MOTHER
14. Maiden Name Rachel Taylor
15. Birthplace Anne Arundel Co. Md

16 (a) Informant Frith B. Sickles
(b) Address 2613 Puget St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Geo. Lawyer H. Holland
(b) Address 1631 Pennsylvania Ave.

19 (a) Oct 11 1945 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1945, at 6p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Oct 10 1945, and that I last saw him alive on Oct 8 1945.

Immediate cause of death: Bronchogenic Cancer — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Lawn M. D.
Address 2703 Hollins Ave. Date signed 10/12/45

VS 150

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33210 G33210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret C. Skeen

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Allen H Skeen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8, 1875

8. AGE: Years 70 | Months 9 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Martin C Donnelly
13. Birthplace Tipperary Ireland

MOTHER
14. Maiden Name Margaret McGuire
15. Birthplace Tipperary Ireland

16 (a) Informant Edward H Skeen
(b) Address 3401 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Godwin
(b) Address 1210 E Pratt St

19 (a) Date received by Local Registrar OCT 14 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1945, at 11 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10th 1945 to Oct 13th 1945, and that I last saw her alive on Oct 13th 1945.

	Duration
Immediate cause of death: Coronary Occlusion	4 days
Due to: Arteriosclerosis	2
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Smith M. D.
Address 100 N Milton Ave Date signed 10/13/45

VS 150

G33211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3447 S Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3447 S Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Musgrage

3 (b) If veteran, name war W

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Earl Musgrage

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21. 1882

8. AGE: Years 63 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Orange Co Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Loncoster
13. Birthplace Va

MOTHER
14. Maiden Name Agnes Saunders
15. Birthplace Va

16 (a) Informant Earl Musgrage
(b) Address 3447 S Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director Wilhelm & Feldmeier Inc
(b) Address 1217 E Lond St

19 (a) OCT 14 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1945 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/24/1945 to 10/13/1945 and that I last saw her alive on 10/12/1945.

Immediate cause of death: Hypertensive cardio vascular disease — Duration: ?

Due to

Due to

Other Conditions: Chronic asthmatic bronchitis — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel
Address 1226 Hanover St. Date signed 10/14/1945.

VS 150

Please answer questions in ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 N. Charles
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah C. Eastburn.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife: Homer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 1885

8. AGE: Years 60 | Months 9 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Lewis
13. Birthplace Md

MOTHER
14. Maiden Name Columbia Trowbridge
15. Birthplace Md

16 (a) Informant Mrs M Morton
(b) Address 2631 N Charles St

17 (a) Burial (b) Date thereof 10/15/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lafayette
Location Lafayette Md

18 (a) Funeral director Tedrow Cohen
(b) Address 1219 E Baltimore St

19 (a) OCT 14 1945 (b) Thurston Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1945, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Knight B. McNally M.D.
Medical Examiner.
Date signed 10/14/45

VS 151

G33213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G33213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1661 Vincent Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1661 Vincent Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIA L. MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Peaker
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. Smith
15. Birthplace Md.

16 (a) Informant Mrs Lola Hines
(b) Address 1661 Vincent Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 14 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 11, 1945, at 3:30 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-7 19 44 to 10-11 19 45
and that I last saw h alive on 11 19

Immediate cause of death: Cerebral Hemorrhage — Duration 1 Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 1 West Lanvale St. Date signed 10-12-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33214

481126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. G33214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1539 Orville Ave (Rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lippitt.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-19-45

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Lippitt
13. Birthplace Penn.

MOTHER
14. Maiden Name Geraldine Peltz.
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Schwartz cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 15 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945 at 8.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1945 to Oct-12 1945 and that I last saw him alive on Oct-12 1945

Immediate cause of death Pneumonia of Newborn — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry H. Smith M.D.
Address Johns Hopkins Hospital Date signed 10-13-45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 633215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3343 Dudley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3343 Dudley Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia C. Weber

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Aug. Weber
6 (c) If alive, give age 62 years
7. Birth date of deceased (mo., day, yr.) July 30. 1883

8. AGE: Years	Months	Days	If less than one day
62	2	19	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Edward Meyer
13. Birthplace Balto.

MOTHER
14. Maiden Name Kath. Wolf.
15. Birthplace Germany

16 (a) Informant Mr. Aug. Weber
(b) Address 3343 Dudley Ave

17 (a) Burial (b) Date thereof Oct 15 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Erdman Ave

18 (a) Funeral director L. HECHINGER & SON
(b) Address 32 S. BROADWAY
OCT 15 1945 Huntington Williams, M.D.
(Date received by local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 11 - 1945, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 - 1945, to Oct 12 - 1945, and that I last saw her alive on Oct 12 - 1945.

Immediate cause of death	Duration
Cerebral Hemmorrhage	7 days
Due to Arteriosclerosis	3 yrs.
Due to Hypertension	
Due to Myocardial Insufficiency	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. G. Geyer
Address 156 N. Milton Ave Date signed 10/13/45 M.D.

G33216

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92D

Registered No. G33216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 W Henrietta
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 W Henrietta St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Boone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1915

8. AGE: Years 30 | Months 2 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Harrison Broom
13. Birthplace Md

MOTHER
14. Maiden Name Etta Banister
15. Birthplace Md

16 (a) Informant Etta Boone
(b) Address 137 W Henrietta St

17 (a) Burial (b) Date thereof 10-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md

18 (a) Funeral director Isaiah L Brown
(b) Address 1845 W Montgomery St

OCT 15 1945
(Date rec'd by registrar)

Huntington Williams Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Oct 12 1945, and that I last saw her alive on Oct 12 1945

Immediate cause of death	Duration
Chronic Nephritis	6 months
Heart Disease	
Due to	
not known	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Lindsay G Shelton M. D.
Address 1016 S. Sharp St Date signed 10/15/45

VS 190

G33217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G33217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 South Potomac St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2 South Potomac Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Schiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, ~~widowed~~, or ~~divorced~~: Married
6 (b) Name of husband or wife: Mary A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 31 - 1881
8. AGE: Years 64 | Months 2 | Days 12 | If less than one day: hr. min.
9. Birthplace: Germany (Town, county and state)
10. Usual Occupation
11. Industry or business: Barber
FATHER 12. Name: Frantz Schiller
13. Birthplace: Germany
MOTHER 14. Maiden Name: Anna Scholtz
15. Birthplace: Germany
16 (a) Informant: Mary A. Schiller
(b) Address: 2 South Stonge Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 15 '45 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Taylor Avenue
18 (a) Funeral director: John C. Moran
(b) Address: 3600 E. Baltimore St.
19 (a) (Date received by registrar) (b) Huntington Williams M.D.

OCT 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945 at 9 05 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Hugh B. McNally M.D. Medical Examiner
Date signed: Oct 14 1945 per Robert L. Taylor M.D.

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

Registered No. G33218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22x W. Biddle
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22x W Biddle St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Ayers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	2	hr. min.

9. Birthplace Balto Co. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name David Ayers
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Jane Hill
15. Birthplace Balto Co. Md

16 (a) Informant Mrs Fanny Ayers
(b) Address 22x W Biddle St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md

18 (a) Funeral director J. L. Preston Lanfeiry
(b) Address 529 Mosher St.

OCT 15 1945

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 19XX, at 3 XX P.M

21. I certify that death occurred on the date above-stated; that I attended deceased from Oct 3 19XX to Oct 11 19XX, and that I last saw him alive on Oct 10 19XX.

Immediate cause of death	Duration
Cardiac Vascular Disease	6 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 928 Park Ave Date signed 10/17/45

X

G33219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33219

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 630 S Curley St.

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County [redacted]

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 630 S. Curley St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Bronislawa (Bertha) Warminski

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Peter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1878

8. AGE: Years	Months	Days	If less than one day
67	5	29	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Jan Mastalerczuk

13. Birthplace Poland

MOTHER 14. Maiden Name Jozefa Adamczuk

15. Birthplace

16 (a) Informant John Warminski

(b) Address 630 S Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Dundalk Ave

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson St.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar, M.D.

JUL 13 1945

VS 19c

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1945 at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to Oct 13 1945 and that I last saw [illegible] alive on Oct 13 1945.

Immediate cause of death ARTERIOSCLEROTIC HYPERTENSIVE CARDIO-VASCULAR — Duration ?

Due to DISEASE

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Fr. Ubaniya

Address 209 L Chester St Date signed 10/15/45 M. D.

G33260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 566 Radnor Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2 10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 566 Radnor Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clifford E. Lawrence

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Esther L. Lawrence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16th. 1896

8. AGE: Years	Months	Days	If less than one day
49	7	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B& O Railroad

FATHER 12. Name Jacob C. Lawrence

FATHER 13. Birthplace New Jersey

MOTHER 14. Maiden Name Mary Bennian

MOTHER 15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Clifford E. Lawrence

(b) Address 566 Radnor Ave. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/1945 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md.

18 (a) Funeral director Leach Funeral Home

(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

OCT 17 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH, October 13th 1945, at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941, to Oct. 13 1945, and that I last saw h[illegible] alive on Oct. 13 1945

	Duration
Immediate cause of death Cerebral Hemorrhage	5 hrs.
Due to Essential Hypertension	8 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Novak M. D.

Address 101 W. Read St Date signed 10-15-45

X X

G33221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G33221 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of county)
(d) Street No. 1508 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aaron Young.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/1906

8. AGE: Years 40 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wilbert Young

13. Birthplace Md.

MOTHER 14. Maiden Name Katie Hughes

15. Birthplace Md.

16 (a) Informant Katherine Harris

(b) Address 1508 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/15/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Pennsylvania Ave

19 (a) (Date rec'd by registrar) OCT 15 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1945, at 10 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions Tuberculous pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Stasulis M.D. Medical Examiner.

Date signed Oct 11, 1945

X

633-22 ✓ 633-22

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Paine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Linwood Meeker ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1941 1945

8. AGE: Years | Months: 6 | Days: 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles B. Meeker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Hermon
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address 3303 Paine St, City 11

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) OCT 15 1945 (Date rec'd by registrar) (b) Huntington Millenville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1945 to Oct. 12 1945 and that I last saw h[illegible] alive on Oct 12 1945.

	Duration
Immediate cause of death Uremia + Respiratory failure	
Due to Acute gastrointestinal disturbance	
Due to	
Other Conditions Otitis media, diarrhea	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Strader M. D.
Address Union Memorial Date signed 10/15/45

Hospital

X S

G33223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G33223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City morgue - 700 East St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 McCulloh Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Caroline County, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Agnes Smith
15. Birthplace Va.

16 (a) Informant Henry Smith (Brother)
(b) Address 1410 Lawrence Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave.

19 (a) (b) Huntington Williams

OCT 15 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma head of pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed 10-13-45

X

633524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93C ✓ Registered No. 633524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KAROL MLYNSKI OR Chas. Mlynski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-0361

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 27-1922

8. AGE: Years 21 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Bethlehem Steel Co

FATHER
12. Name STANISLAW MLYNSKI
13. Birthplace POLAND

MOTHER
14. Maiden Name ALBINA KOZLOWSKI
15. Birthplace Baltimore Md

16 (a) Informant Mrs Albina Mlynski
(b) Address 617 S Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-43 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location Brooklyn, A.A. Co

18 (a) Funeral director George A Weber
(b) Address 705 S Ann street

19 (a) OCT 15 1943 (Date rec'd by registrar) (b) Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1943, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rheumatic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Pulvinski M.D. Medical Examiner.
Date signed 10/27/43

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33225

HB #96566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 122

G33225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Ridgely St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Elben Mary Carlisle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William Carlisle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1886

8. AGE: Years	Months	Days	If less than one day
59	0	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Duckett
13. Birthplace Maryland

MOTHER
14. Maiden Name Katharine McHale
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters Cem
Location Balto Md

18 (a) Funeral director Bernard E Harle
(b) Address 121 E West St

19 (a) OCT 15 1945 (b)
Date received by Registrar Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1945 at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1945 to Oct. 12 1945, and that I last saw her alive on Oct. 12, 1945

Immediate cause of death	Duration
Nephritis & anuria	4 days
Uremia	4 days
Due to Incarcerated ventral hernia & intestinal obstruction	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/9/45

Major findings of operation: Incarcerated ventral hernia

of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Berry MD
Address Balto City Hosps Date signed 10/13/45 M. D.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33426 ✓ G33426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 2316 Frederick Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Hook (Edward J. Jr.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10.6.45

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward James

13. Birthplace Md.

MOTHER 14. Maiden Name Marie Hershey

15. Birthplace Md.

16 (a) Informant Mr Edward Hook

(b) Address 2316 Frederick Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10.15.45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 3400 Old Frederick Rd

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Hollins, M.D.

OCT 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1945, to 10/13 1945. and that I last saw h[illegible] alive on 10/13 1945.

Immediate cause of death Asphyxia from obstructing laryngo-tracheo bronchitis

Due to Trachea too small to permit #1 tracheotomy tube to be passed

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature L. D. DeElia Jr.

Address St Agnes Hosp Date signed 10/14/45

X

6336-27

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. 6336-27

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Ave. & Cloverdale Rd. Temple Garden Apts.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM E. GOLDSMITH.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Belle A. Goldsmith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1867.

8. AGE: Years	Months	Days	If less than one day
About 78			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Real Estate.
11. Industry or business

FATHER
12. Name Edward Goldsmith,
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Hutzler,
15. Birthplace Germany.

16 (a) Informant Mr. Milton Hirshberg,
(b) Address 2217 Linden Ave.

17 (a) Burial (b) Date thereof 10. 15. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Har Sinai
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) (b) Huntington Williams, M.D.
Registrar

OCT 15 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13th. 1945, at 11-40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Oct 13 1945, and that I last saw him alive on Oct 13 1945.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Cardio renal disease	3 mos
Due to Arteriosclerosis	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lentz M. D.
Address Temple Garden Apts. Date signed Oct 16 45

X

Please write plainly, with pen and ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WERNECKI

633428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

633428 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Hilkins & Caton Aves

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 223 So Clinton Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Adelaide Wernecki

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1881

8. AGE: Years 64 Months 2 Days 26 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business own home

FATHER 12. Name George Lanier

13. Birthplace Maryland

MOTHER 14. Maiden Name Christina Spracher

15. Birthplace Maryland

16 (a) Informant Son John H.

(b) Address 483 N Bradley Blvd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 16/45 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BELAIR ROAD

18 (a) Funeral director Tilly & Zeiler Inc.

(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) OCT. 15 1945 (b) Registrar Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13 1945, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1945 to 10/13 1945.

and that I last saw h CM alive on 10/12 1945.

Immediate cause of death Acute Cardiac Failure

Due to Probable Heart Block

Due to Hypertension C-V Dis. & Decompensation.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 10/13/45

633629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

633629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 North Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania County Allegheny
(c) City or town Bellevue Pittsburgh
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Lincoln Terrace Apartments
(If in institution, give name)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT WILLIAM COTTON

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 712-16-5525

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Bennie
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 26 1877

8. AGE: Years: 68 | Months: 4 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Centreville Pa. (Town, county, and state)

10. Usual Occupation: Physician

11. Industry or business:

FATHER
12. Name: William Cotton
13. Birthplace: Centreville Pa.

MOTHER
14. Maiden Name: Emma V Young
15. Birthplace: Monongahela Pa.

16 (a) Informant: Mrs. Robert W. Cotton
(b) Address: Bellevue Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 16 1945 (month) (day) (year)
(c) Cemetery or crematory: Taylor
Location: Centreville Pa.

18 (a) Funeral director: Henry W. Eakins Sons
(b) Address: McCulloch & Orchard

19 (a) OCT 15 1945 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14/45 19..., at 1:90 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: John R. Davis, M.D.
Medical Examiner.
Date signed 10/14/45

Huntington Williams Inc.

G33430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33430 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Belvieu Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry M Beck

3 (b) If veteran, name war: None
(c) Social Security Account No. None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: J. Eloise Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1876

8. AGE: Years 69 | Months 5 | Days 25 | If less than one day: hr. min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation Insurance Adjuster

11. Industry or business

FATHER
12. Name James P Beck
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Martha J. Lockerby
15. Birthplace Kentucky

16 (a) Informant James B. Beck
(b) Address 4211 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Aves., Balto., Md.

19 (a) OCT 15 1945 (Date received by Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12/1945 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1945 to Oct 12 1945 and that I last saw him alive on Oct 12 1945

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. H. Steiden Jr

Address Mercy Hospital Date signed 10/14/45

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

633631 Registered No.

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Sts.
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Devine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1864

8. AGE: Years 81 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Rockville Md
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Michael Laney
13. Birthplace unknown

MOTHER
14. Maiden Name Mary Sullivan
15. Birthplace Ireland

16 (a) Informant Mrs. M. Bauser
(b) Address 230 Summit Ave Hagerstown Md

17 (a) Removal (b) Date thereof 10/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md.

18 (a) Funeral director Fred W. Kraiss
(b) Address Hagerstown Md.

19 (a) OCT 15 1945 Clayton Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 14 1945 and that I last saw h[illegible] alive on Oct 14 1945.

	Duration
Immediate cause of death Myocarditis	1 yr.
Due to	
Due to	
Other Conditions Nephritis	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Janet Frahn
Elmer Hall M. D.
Address Date signed

VS 180

G33632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G33632 Registered No.

Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4710 Pilgrim Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4710 Pilgrim Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH ANN MARGARET ALBRECHT

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William F. Albrecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1871

8. AGE: Years	Months	Days	If less than one day
73	11	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Gith
13. Birthplace Germany

MOTHER
14. Maiden Name Anna D. Cole
15. Birthplace Balto., Md.

16 (a) Informant Mr. William F. Albrecht
(b) Address 4710 Pilgrim Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1935, to 1945, and that I last saw h[illegible] alive on 10-13 1945.

Immediate cause of death	Duration
Arteriosclerotic myocarditis	10 yrs.
Due to Generalized arteriosclerosis	
Due to -	
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Bohmeister M. D.
Address 54 S. Fulton Ave Date signed 10-14-45

VS 150

Huntington Williams, M.D.

X

G33433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 529 Rossiter Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 529 Rossiter Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva F. Small

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Newton B. Small
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1856

8. AGE: Years	Months	Days	If less than one day
89	1	23	hr. min.

9. Birthplace Knobsville, Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Polk
15. Birthplace Pa.

16 (a) Informant Miss Eleanor R. Small
(b) Address 529 Rossiter Ave.

17 (a) Burial (b) Date thereof Oct. 16, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Presbyterian
Location Hancock, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1945 at 6:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1941 to Oct. 13 1945 and that I last saw her alive on Oct. 13 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Earl H. Benson M.D.

Address 511 York Rd Date signed Oct. 15, 1945

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

84B 613 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Doyle (Annie M. Doyle)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	F	W	Widowed

6 (b) Name of husband or wife Edward J. Doyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1886

8. AGE: Years	Months	Days	If less than one day
59	8	15	hr. min.

9. Birthplace Texas, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Price
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Rose Barrett
15. Birthplace Texas, Md.

16 (a) Informant Mrs. Harry W. Poehler
(b) Address 823 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Notth & Penna Aves.

19 (a) OCT 1 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1945, at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1945 to 10/12 1945, and that I last saw her alive on 10/12 1945.

	Duration
Immediate cause of death respiratory failure	2 hr.
Due to post operative effect frontal lobectomy	
Due to	
Other Conditions Schizophrenia	8 yr.

(Include pregnancy within 3 months of death)
Date of operation 10/12/45
Major findings of operation: hemorrhage into operative site
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Doenges M.D.
Address University Hosp Date signed 10/13/45

G33235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G33235 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave. & Rokeland St.
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Ridgehill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Elmer Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Carrie H. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto. City

FATHER
12. Name Harry Taylor
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alice Rider
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Carrie H. Taylor
(b) Address 2012 Ridgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ /45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

OCT 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1945 to 10/14 1945, and that I last saw h/m alive on 10/14 1945

Immediate cause of death Cardiac Failure
Due to Acute Pulmonary Edema
Due to Renal Suppression (Hepato-renal syndrome)
Other Conditions

Duration
1 day

(Include pregnancy within 3 months of death)
Date of operation 10/10/45
Major findings of operation: chronic cholecystitis; chronic appendicitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alberto Adams M. D.
Address West Baltimore General Hospital Date signed 10/14/45

Huntington Tuberculosis

G33436 Shilman

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33236 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1909 Ruxton Ave

(c) Hospital or institution: Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 1909 Ruxton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Morris Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	M	

6 (b) Name of husband or wife Fern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name

13. Birthplace Russia

MOTHER

14. Maiden Name

15. Birthplace Russia

16 (a) Informant Eli Sherman

(b) Address 2309 Tioga Parkway

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew Cem

Location Loudon Ave

18 (a) Funeral director Joel Lewis Inc.

(b) Address 1429 E. Baltimore St.

19 (a) Oct. 15 1945 (Date rec'd by registrar) OCT 15 1945 (b) Registrar's number

OCT 15 1945 Washington Hillcrest, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945, to Oct 14 1945, and that I last saw him alive on October 14 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive C.V. Disease	
Due to Arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature N. E. Needle M. D.

Address 814 W. North Ave Date signed 10/15/45

X

633637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 633637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Dukeland & Raynor

(c) Hospital or institution: West Balto Gen'l Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1913 Mc Kean Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Fannie Pasker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Isadore Pasker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alexander Meyerhoff

13. Birthplace Russia

MOTHER 14. Maiden Name Hana Rufka

15. Birthplace Russia

16 (a) Informant M. Oscar Meyerhoff

(b) Address 2301 Ocala Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)

(c) Cemetery or crematory Windsor Mill Gard

Location

18 (a) Funeral director Jack Laura Inc

(b) Address 1798 E. Balto St

19 (a) OCT 15 1945 (Signature of Registrar) Huntington Wattis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1945, at 12 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1945 to Oct 15 1945, and that I last saw her alive on Oct 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Failure	
Due to Cerebral Hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Benjamin Berdinsky M. D.

Address W. B. G. H. Date signed 10-15-45

VS 150

For B. H. McNally - by Howard J. Mercer, M.D.

G33238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33238

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3/4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 3/4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3744 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Russo

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/45

8. AGE: Years	Months	Days	If less than one day
		1	18 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Benjamin Russo
13. Birthplace

MOTHER
14. Maiden Name Margaret Toocker
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Oct 15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Frank V. Peterlong
(b) Address 2218 E. Baltimore St

19 (a) OCT 15 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 14 1945
and that I last saw him alive on Oct 14 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Prematurity & Immaturity	1½ days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Milton Linthicum
Address Mercy Hospital Date signed 10/15/45
M. D.

VS 150

633239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 633239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lanvale
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3344 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Russo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1945

8. AGE: Years	Months	Days	If less than one day
			8 hr. 5 min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mr. Benjamin Russo

13. Birthplace

MOTHER 14. Maiden Name Margaret Mancini

15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Russo (Mother)

(b) Address 821 Eutaw Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15. 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank V. Pipitone

(b) Address 2818 E. Baltimore St.

OCT 15 1945 (Date rec'd by registrar) Signature for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1945, at 1:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945, to Oct 13 1945 and that I last saw him alive on Oct 13 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Immaturity & premature birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Myers M. D.

Address Mercy Hospital Date signed 10-13-45

VS 150

X

This certificate, when completed, will be typewritten, with ONE ENTRY INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1194

Registered No. 63340

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Ave

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1946 Linden Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Jean ~~Baby~~ Peggy Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1944

8. AGE: Years	Months	Days	If less than one day
	10	16	hr. min.

9. Birthplace Md Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Charles Hunt

13. Birthplace Md Balto Co., Md

MOTHER

14. Maiden Name Marie Roberts

15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Marie Roberts

(b) Address 1946 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1945 (month) (day) (year)

(c) Cemetery or crematory Black Rock

Location Balto Co., Md.

18 (a) Funeral director Landon M. Brooks

(b) Address Sparks, Md.

19 (a) (b)

(Signature of local registrar) Registrar

OCT 15 1945

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1945 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1945 to 10/14 1945, and that I last saw h/E alive on 10/14 1945.

Immediate cause of death Overwhelming Pneumonia d/t Resp. Failure

Due to Acute Bronchitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. E. Cassard Jr. M.D.

Address St. Agnes Hosp. Date signed 10/14/45

633451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633451

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Cockeysville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ashland Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Sophie Bosley

3 (b) If veteran, name war: No

3 (c) Social Security Account No. –

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter A. Bosley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 27, 1894

8. AGE: Years 51 | Months 7 | Days 17 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John F. Tillman
13. Birthplace: Balto. Co., Maryland

MOTHER
14. Maiden Name: Barbara Snyder
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Walter A. Bosley
(b) Address: Cockeysville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)

(c) Cemetery or crematory: Int. Zion
Location: Upperco, Balto. Co.

18 (a) Funeral director: Sowden McDooley
(b) Address: Sparks, Md.

19 (a) OCT 15 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1945, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of Brain, Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-11-45 9:50 A.M.
(b) Where did injury occur? Ashland Road, Cockeysville, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Passenger in car which ran into ditch & turned over.

23. Signature: Robert Lee Graham, M.D.
Medical Examiner.
Date signed October 14, 1945.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G33242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 W. Camden st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 W. Camden st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Concetta Palmisano

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Salvatore Palmisano
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1870

8. AGE: Years	Months	Days	If less than one day
75	6	3	hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Santo Purpora
13. Birthplace Italy

MOTHER
14. Maiden Name Francesca Russo
15. Birthplace Italy

16 (a) Informant Son Chas Palmisano
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 | 15 | 45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pisaltone
(b) Address 218 E. Baltimore st

19 (a) Oct 15 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1930, to Oct 12 1945, and that I last saw her alive on Oct 12 1945.

Immediate cause of death	Duration
Cardio-Vascular Hypertension	10 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. S. J. Pansano, M.D.
Address 436 E Fayette Balto 2 Md Date signed 10/16/45

VS 150

G33443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G33443

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1064 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1064 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Essie Reid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1895

8. AGE: Years	Months	Days	If less than one day
50	-	21	hr. min.

9. Birthplace Winsloe N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Outlaw
13. Birthplace N. C.

MOTHER
14. Maiden Name Maggie Baymore
15. Birthplace N. C.

16 (a) Informant Essie Green
(b) Address 1064 W. Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 DEC 15 1945 (Registered by registrar) (b) Huntington West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1945, at 10:15 A. M.

21 I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral embolism
Cardio vascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert Lee Foster M.D. Medical Examiner.
Date signed 10-11-45

VS-151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 633-44

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 W. Hoffman
(c) Hospital or institution: 61
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 W. Hoffman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Robert Green
13. Birthplace Md.

MOTHER 14. Maiden Name Martha Green
15. Birthplace Md.

16 (a) Informant Amelia Chaney
(b) Address 617 W. Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 15 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1945 at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary sclerosis
cardiovascular - renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 10-11-45

Huntington Williams, M.D. Registrar

VS 151

X

G33245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 106 N. Fremont Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 106 N. Fremont Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emanuel Summerfield

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col	married

6 (b) Name of husband or wife Lillian Summerfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1876

8. AGE: Years	Months	Days	If less than one day
69	10	10	hr. min.

9. Birthplace Aaco Md

(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER

12. Name John Summerfield

13. Birthplace Aaco Md

MOTHER

14. Maiden Name Cora Young

15. Birthplace Baltimore Md

16 (a) Informant Ed Summerfield

(b) Address 1818 W Lexington

17 (a) Burial (b) Date thereof 10-16-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St

OCT 15 1945

(Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Oct 12 1945, and that I last saw h— alive on Oct 12 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 yrs
Due to Hypertension	
Due to Kidney trouble	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature David Trunkey M. D.

Address 1 W Lex Ave Date signed 10/12/45

633246 BALTIMORE CITY HEALTH DEPARTMENT 633249
CERTIFICATE OF DEATH
Registered No. 1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W. Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmer Nelums Nelymer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Josephine Brown
15. Birthplace

16 (a) Informant Josephine Brown
(b) Address 622 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 15 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1945, at 1:45 P. M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bilateral Chronic Pulmonary Tuberculosis with cavities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard E. Clemens M.D. Medical Examiner.
Date signed October 12, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 N. Poppleton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Poppleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Giles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Delta, Pa.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Giles
13. Birthplace Delta Pa

MOTHER
14. Maiden Name Mary
15. Birthplace Delta Pa.

16 (a) Informant Mrs Virgie Giles
(b) Address 410 N. Poppleton St

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 10-17-'45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Mt.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945 at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerular Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
By Means of injury

23. Signature Paul Lee Easter M.D.
Medical Examiner.
Date signed 10-13-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633428 633428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Jones Sts

(c) Hospital or institution:

University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 707 W. Redwood St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Maude Beane

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Cook

13. Birthplace Maryland

MOTHER 14. Maiden Name Lottie Cook

15. Birthplace Maryland

16 (a) Informant Edna Beane

(b) Address 709 W. Redwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St

19 (a) OCT 15 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945 at 6:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1945 to Oct. 1 1945. and that I last saw her alive on Oct. 1 1945.

Immediate cause of death	Duration
Septic pneumonia	
Due to Bilateral Cirrhosis (Edema) Anasarca	
Due to Bilateral Obstruction due to Salpingitis?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/3/45

Major findings of operation: Cirrhosis of liver

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. B. Anderson M. D.

Address University Hospital Date signed 10/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33649 G33649

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 142B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lenox Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 30 m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 W Lexington (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Lee Tucker Boston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Wm Boston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace Columbia, S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Marion Tucker.
13. Birthplace Columbia, S.C.

MOTHER
14. Maiden Name Rosie Taylor.
15. Birthplace Columbia, S.C.

16 (a) Informant Mr. William Boston
(b) Address 917 W. Lexington St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-16-'45 (month) (day) (year)
(c) Cemetery or crematory
Location Columbia S.C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3215 W Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1945, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-1945 to 10-12 19..., and that I last saw her alive on 10-12-45 19...

Immediate cause of death: acute abd hemorrhage

Due to: Ectopic pregnancy

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard D. Hoover M.D. M. D.

Address Date signed

VS 150

X

633250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8312

633250 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2842 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2842 Hudson Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA PHILOMENA SCHIMUNEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Albert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1846

8. AGE: Years	Months	Days	If less than one day
99 yrs.	-	11	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Jedlicka
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name unknown
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Ludmila Schimunek
(b) Address 2842 Hudson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 10-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1945 at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1945 to Oct 11 1945 and that I last saw h~~er~~ alive on Oct 11 1945.

Immediate cause of death Cerebral Thrombosis — Duration 3 days
Due to Arteriosclerosis generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Klimes M.D.
Address 2623 E. Monument Date signed 10/13/45

VS 180

633251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

633251

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) P

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reisterstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Nicodemus Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Rawlins Ran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/1/1883

8. AGE: Years	Months	Days	If less than one day
62	4	13	hr. min.

9. Birthplace Reisterstown Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Ran
13. Birthplace Maryland

MOTHER
14. Maiden Name Sophie L. Lloyd
15. Birthplace Maryland

16 (a) Informant Mrs. Roy Ran.
(b) Address Reisterstown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Reisterstown, Md

18 (a) Funeral director Wm. O. Gray Mary Sons
(b) Address Reisterstown, Md.

(a) OCT 15 1945 (b) (Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14, 1945 at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck

Due to Fractures Pelvis.
Fractured leg bones.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-13-45 at 6 45 P. M.
(b) Where did injury occur? Reisterstown, Route #140 & Old Road
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? NO
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 10-15-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 633452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Echodale Ave. Balto, Md.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Poole, John Henry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Poole
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1878

8. AGE: Years	Months	Days	If less than one day
67	+	28	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation painter
11. Industry or business

FATHER
12. Name George Poole
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Joanna Bull
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5905 Harford Road

19 (a) Oct 15 1945 (Date received by local registrar) (b) Washington Wilkins, M.D. (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1945, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1945, to Oct. 13 1945, and that I last saw him alive on Oct. 13 1945.

Immediate cause of death	Duration
Arteriosclerotic heart disease with congestive failure.	uncertain
Due to Congestive failure	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Wilson
J. L. Wilson, Sr. Surgeon US PHS M. D.
Address U.S. Marine Hospital, Baltimore, Md. Date signed

4816506333653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

G333653

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Johns Hopkins Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 304 S. Dunham St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Koczorowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-18

8. AGE: Years	Months	Days	If less than one day
27	6	13	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Stock Warehouse

11. Industry or business

FATHER 12. Name Michael Koczorowski

13. Birthplace Poland

MOTHER 14. Maiden Name Kathryn

15. Birthplace Poland

16 (a) Informant Records.

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 16 45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 408 S. Chester Street

19 (a) (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

OCT 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945 at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1945 to Oct 12 1945 and that I last saw him alive on Oct 12 1945.

Immediate cause of death	Duration
Uraemia	
Due to chronic glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Evelyn G. Vance, M.D.

Address Johns Hopkins Hospital 10/12/45

G33254

CWK-94421

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12 B

G33254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 3 14
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Middle River
(c) City or town Middleborough Box 271
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Mielcarek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Valeire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
56	—	—	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bolaslaw Mielcarek (D)
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Polnad

16 (a) Informant Hedwig Mielcarek
(b) Address 1614 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Dalto. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) OCT 15 1945 Registered (b) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945, to Oct. 12 1945, and that I last saw him alive on Oct. 12 1945.

Immediate cause of death Pulmonary tuberculosis, cavitation, left upper, right middle — Duration

Due to Spontaneous pneumothorax ?

Other Conditions Cavitation left upper right middle lobe
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Rowland M. D.
Address DCH Date signed 10/17/45

VS 150

633255 633255

BALTIMORE CITY HEALTH DEPARTMENT 1094 Registered No.
CERTIFICATE OF DEATH 126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Since Coma

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) Chas. St or Homeland Sta
(d) Street No. Convent of Notre Dame (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Celestine Zang

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	18	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Sebastian Zang
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schaefer
15. Birthplace Germany

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16 45 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm

18 (a) Funeral director Geo M. Frank Sons
(b) Address 811 N Wolfe St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 15 1945 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1945, 19 , at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 19 45, to Oct 13 19 45, and that I last saw her alive on Oct 13 19 45.

	Duration
Immediate cause of death Respiratory failure	8 hrs
Due to Acute distension	12 hrs
Due to Megalocolon + Adhesions	2
Other Conditions Cholelithiasis Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Megalocolon Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Dattoli Jr. M. D.
Address Mercy Hospital Date signed 10/14/45

X

CAUSE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633656 BALTIMORE CITY HEALTH DEPARTMENT 633656

CERTIFICATE OF DEATH ✓ 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1629 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kotka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W.

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 79			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Geo Kotka

(b) Address Ronaldson Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Clarence P Hoffman

(b) Address 1639 N Broadway

19 (a) Date received OCT 19 1945 (b) Registrar Washington Hillsdale, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1945, at 11:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxiation due to large hematoma of the neck pharynx and trachea.

Due to

Other Conditions Small bruise burn, contusion neck, left.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct 13 at - M.

(b) Where did injury occur? Home 1629 E. Eager St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?

(d) Means of injury Fell out of bed.

23. Signature Benedict Shtarelis M.D.
Medical Examiner.

Date signed 10/15/45

G33857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G33857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3821 Fourth Ave - E. Brooklyn
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3821 Fourth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grady K Savage Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1945

8. AGE: Years | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Grady Kater Savage Sr.
13. Birthplace Gladsden Ala.

MOTHER 14. Maiden Name Mildred E. Goodwin
15. Birthplace Baltimore Md.

16 (a) Informant Father
(b) Address 3821 4th Ave E. Brooklyn

17 (a) Burial (b) Date thereof 10/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) OCT 15 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1945 at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Marasmus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 10/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 S. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mak Wisolek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-45

8. AGE: Years	Months	Days	If less than one day
			7 hr. 40 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Wisolek
FATHER 13. Birthplace Baltimore

MOTHER 14. Maiden Name Charlotte Frampton
MOTHER 15. Birthplace Baltimore

16 (a) Informant Birth Certificate
(b) Address #

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 15 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 15 1945 (Date received by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12-45 (10-12-45) 1945 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Prematurity

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jones Falcon M. D.
Address 10/14/45 Date signed

VS 150

3007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33439

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home + Hospital No. 3
(d) Length of stay in hospital or inst. (yrs., mos., ~~or days~~) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home + Hospital (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Charlotte S. mead Charlotte West Smead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edwin Julius Smead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1863

8. AGE: Years 82 | Months 7 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Oakland, Md. (Town, county, and state)

10. Usual Occupation Retired Hsw.

11. Industry or business

FATHER
12. Name Horace West
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Lyle West
15. Birthplace Virginia

16 (a) Informant Mr. E. J. Smead, Jr.
(b) Address 1134 Oakhill Ave., Hagerstown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Gilbert Funeral Home
(b) Address 4510 Liberty Heights Ave Hunting Town Williams, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 15 1945

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1945, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-1945, to 10-14 1945, and that I last saw h... alive on 7-25-1945.

	Duration
Immediate cause of death Cerebral Vascular accident	
Due to Cerebral arteriosclerosis Hypertension	
Due to	
Other Conditions Asphyxiation with broncho pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred M. Hughes M. D.
Address Church Home H. Date signed 10-14-45

X

G33660 BALTIMORE CITY HEALTH DEPARTMENT G33660
Registered No.
CERTIFICATE OF DEATH 195E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 John Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James G. Spahn

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-3365

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lavinie Spahn

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1897

8. AGE: Years 47 | Months 9 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Md. Refrigeration Co.

FATHER
12. Name Jacob G. Spahn
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Lavinie Spahn
(b) Address 1604 John street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baker Road-

18 (a) Funeral director Clay F. Evans & Sons
(b) Address 118 W. Mt. Royal Ave.

19 (a) 1945 (Date this copy registered) (b) Registrar for Williamsburg Township

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 45 19 , at 7:55 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull

Due to

Other Conditions Epidural Hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-12? at ? P. M.
(b) Where did injury occur? ?
(c) Did injury occur at home, on farm, industrial place, in public place? Home ? While at work? No
Details of injury Found lying in a vestibule

Signature Howard J. Mueseler M.D.
Medical Examiner.
Date signed October 13, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178A

G33651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Elizabeth Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ira Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1915

8. AGE: Years	Months	Days	If less than one day
20 29	9	15	14 hr. min.

9. Birthplace Aurora N.C.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Swain
13. Birthplace N.C.

MOTHER
14. Maiden Name Laura Spencer
15. Birthplace Aurora N.C.

16 (a) Informant Ira Allen
(b) Address Aurora, N.C.

17 (a) 10-17-45 (b) Date thereof Burial
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hardy Grove
Location Aurora N.C.

18 (a) Funeral director John E. Miller Jr.
(b) Address 2445 E. Oliver St.

19 (a) 1945 Registered by registrar Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945, at 12:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 A.M. at 10:15 A.M. (14)
(b) Where did injury occur? 3044 Hudson St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Asphyxiated due to gas fumes

23. Signature Homer J. Mercer M.D.
Medical Examiner.
Date signed 10-15-45

(OVER)

633262

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

633262
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County HARFORD
(c) City or town BEL AIR
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D. # 2
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN G. HOOPER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife BESSIE L. HOOPER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT. 15, 1885

8. AGE: Years 60 | Months 1 | Days | If less than one day ____ hr. ____ min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSE PAINTER

11. Industry or business

FATHER
12. Name CHRISTOPHER HOOPER
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY OREM
15. Birthplace MARYLAND

16 (a) Informant WIFE
(b) Address SAME

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1945 (month) (day) (year)
(c) Cemetery or crematory Fork Christian Cem
Location Fork Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) 10-15-1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 15, 1945, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1945, to 10/15 1945, and that I last saw him alive on 10/15 1945.

Immediate cause of death CARDIAC FAILURE — Duration

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Due to

Other Conditions ARTERIOSCLEROSIS, GENERALIZED.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm. E. Speed III M. D.
Address Union Memorial Hosp. Date signed 10/14/45

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33263 ✓ G33263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Mt. Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 5 44

8. AGE: Years	Months	Days	If less than one day
1	6 18	9	hr. min.

9. Birthplace Frederick Co., Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Bell
13. Birthplace Maryland.

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant George Bell
(b) Address Libertytown, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1945 (month) (day) (year)
(c) Cemetery or crematory New Londen Cem.
Location New London Md.

18 (a) Funeral director Powell & Hoyle
(b) Address Libertytown Frederick, Md.

19 (a) Date received by registrar Oct 17 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1945 at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1945 to Oct. 14 1945.
and that I last saw him alive on Oct. 14 1945.

Immediate cause of death: Acute Lymphatic Leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm A. Holbrook M. D.
Address Univ. Hosp. Date signed 10-15-45

VS 150

G33264 X ✓ G33264

BALTIMORE CITY HEALTH DEPARTMENT 48a Registered No.

CERTIFICATE OF DEATH

G33264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Roxboro N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME • Rita V. Surgear

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilson S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-16

8. AGE: Years 29 | Months - | Days 19 | If less than one day: hr. min.

9. Birthplace Wash D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Clayton C. Vermillion
13. Birthplace Md

MOTHER 14. Maiden Name Bertha Riddle
15. Birthplace D.C

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)
(c) Cemetery or crematory Wash Dr
Location

18 (a) Funeral director Carl L. Hess
(b) Address 715 Eight St

19 (a) Date rec'd by registrar 10 15 1945 (b) Registrar's signature Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 17 1945 to Oct 15 1945 and that I last saw her alive on Oct 15 1945

Immediate cause of death: Carcinomatosis, liver Lungs, pelvis + bladder — Duration: 3 yrs

Due to: Carcinoma of cervix

Due to:

Other Conditions: Hydronephrosis + hydroureter bilateral — Duration: ?1 yr.
(Include pregnancy within 3 months of death)

Date of operation October 1942

Major findings of operations: Carcinoma of cervix

of autopsy: Carcinomatosis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard B. Clark M. D.
Address Johns Hopkins Hosp Date signed 10/15/45

VS 150

X

633265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 200C

Registered No. 633265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 00 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 E. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5318

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1867

8. AGE: Years	Months	Days	If less than one day
6578	9	8	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Richard Cook
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Kuhn
15. Birthplace Germany

16 (a) Informant Chas. H. Cook
(b) Address 2705 H. McElroy Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16-45 (month) (day) (year)
(c) Cemetery or crematory St Paul the Lutheran Cem
Location Balto.

18 (a) Funeral director J. F. Cline Sons
(b) Address Reisterstown Md.

OCT 16 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1945 at 4 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Impossible to determine due to advanced pulmonary fracture changes.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland A. Feinstein M.D. (Medical Examiner.)
Date signed Oct. 15 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

633266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6003 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

27-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6003 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

/

3 (a) FULL NAME ELIZABETH M. BURNS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex 7. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Richard H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1870

8. AGE: Years 75 | Months 7 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business own home

FATHER
12. Name Thomas Gordon
13. Birthplace England

MOTHER
14. Maiden Name Mary Ann Lacy
15. Birthplace England

16 (a) Informant H. B. Gordon
(b) Address 1617 Sulgrave Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Filed) OCT 16 1945 (Signature of registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1945 to Oct 14 1945 and that I last saw h alive on 19

Immediate cause of death	a Duration
Bronchopneumonia	
Due to Fractured Left (11a) Leg	
Due to	
Other Conditions Arteriosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 1 1945 at M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at Home (Specify type of place) While at work? no
(e) Means of injury fall down two flights of stairs
23. Signature Leonard Wallenstein
Address 678 W. 36th St Date signed 10/18/45 M. D.

VS 150

For H. B. McNally by Howard J. Andersen, M.D.X

633267

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No. 633267

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 N Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 N Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Oliver C Hughes

3 (b) If veteran, name war: 1o
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fillmore C Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1 1880

8. AGE: Years 65 | Months — | Days 14 | If less than one day: hr. min.

9. Birthplace Chase Md
(Town, county, and state)

10. Usual Occupation Conductor
11. Industry or business B. R. R.

FATHER
12. Name Fillmore Hughes
13. Birthplace Chase Md

MOTHER
14. Maiden Name Stump
15. Birthplace Chase Md

16 (a) Informant Fillmore Hughes
(b) Address 1912 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 18 45 (month) (day) (year)
(c) Cemetery or crematory Union
Location Glenn Cook Rd

18 (a) Funeral director Fillmore Hughes
(b) Address 2417 Li Forest St

19 (d) OCT 16 1945 (Date rec'd by registrar) (e) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1945 to Oct 14 1945, and that I last saw h[illegible] alive on Oct 14 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 12hrs
Due to: Hypertension Cardio-vascular Renal Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Wolfe M. D.
Address 1331 Hartford Ave Date signed Oct 15 45

VS 150

PRINCE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. 633268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3036 Brighton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ###
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Daum

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 214-01-6118

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Married

6 (b) Name of husband or wife Naomi E. Daum
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) March 9, 1893

8. AGE: Years	Months	Days	If less than one day
52	7	5	..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Electrical

FATHER
12. Name John Daum
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Sellman
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Naomi E. Daum
(b) Address 3036 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

OCT 16 1945 (Date received by local registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1940, to Oct 14 1945, and that I last saw h-- alive on Oct 14 1945.

Immediate cause of death	Duration
Coronary Thrombosis	About
Due to Hyper-tension	10 yrs
Due to Also may not be due to Pneumonia of July '40	2 wks.
Other Conditions 2nd	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. S. French M.D.
Address 2379 Arunah Date signed 10/15/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931 Registered No. 63326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 S. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 406 S. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar J. Van Lill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21 1888

8. AGE: Years	Months	Days	If less than one day
56	10	21	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name Charles Van Lill
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Bloom
15. Birthplace Maryland

16 (a) Informant Mrs Groves
(b) Address 209 S. Milton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (c) OCT 16 1945 (Date received by Registrar) (b) Penalty for Willfully M.P. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 14 1945, and that I last saw him alive on 10/14 1945.

Immediate cause of death Hypertension
Heart disease — Duration 1 yr

Due to

Due to

Other Conditions Cerebral Hemorrhage — 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.
Address 2036 E. Eager Date signed 10/17/45

X ave

6336-D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 6336-D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Woodington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 woodington Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Weller

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late John H. Weller Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1864

8. AGE: Years 81 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Fatgenhorst
13. Birthplace Md

MOTHER
14. Maiden Name Rebecca Bregel
15. Birthplace Md.

16 (a) Informant Marie Danzeglock
(b) Address 819 woodington Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Gay St.

18 (a) Funeral director Harry H. Mitte
(b) Address 410 E Edmondson Ave

19 OCT 16 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14/45 19 , at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1945 to Oct 13 1945, and that I last saw her alive on Oct 13 1945.

	Duration
Immediate cause of death Myocarditis - Acute dilatation of heart	✓
Due to Chronic Interstitial	
Due to Nephritis	✓
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work?
(e) Means of injury ✓

23. Signature John A. Kirkland M.D.
Address 1219 Eastern Ave Date signed 10/15/45.

VS 150

X0

G33671 ✓ G33671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 S. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 S. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Anna Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late Samuel H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1864

8. AGE: Years	Months	Days	If less than one day
81	4	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Jacob Forney
13. Birthplace Penna

MOTHER
14. Maiden Name Eliza Baker
15. Birthplace Md

16 (a) Informant Mrs Susie Monnagle
(b) Address 624 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.16.45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md

18 (a) Funeral director Harry A Weitzke
(b) Address 4101 E Monument Ave

OCT 16 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1945 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 13 1945, and that I last saw h alive on 10/13 1945.

Immediate cause of death	Duration
arterio-sclerotic cardio-renal kidney disease.	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.

Address 2030 Wilkens ave Date signed 10/15/45

VS 150

633272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 633272

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Carroll Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William White

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-0936

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Dora R. Sutton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	11	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Shipper

11. Industry or business Allen E. Barton

FATHER
12. Name William
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda
15. Birthplace Maryland

16 (a) Informant Mrs Dora R White
(b) Address 1713 Carroll Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.17.45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md

18 (a) Funeral director Harry A Wilson
(b) Address 4101 Edmondson Av

19 OCT 16 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/ 1945 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1945 to 10/13 1945 and that I last saw h[illegible] alive on 10/13 1945.

Immediate cause of death Mesenteric Thrombosis
Hemorrhage Bowel
Due to Generalized arterio-sclerosis
Due to

Other Conditions Arteriosclerosis Both Lungs - Pneumonia
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Routh M.D.
Address St. Agnes Hosp. Date signed 10/13/45 M. D.

VS 180

633273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 633273

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Abbottston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Abbottston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara V Stallings

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1882

8. AGE: Years 63 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Kastner
13. Birthplace Germany

MOTHER 14. Maiden Name Deborah Hobbs
15. Birthplace Md

16 (a) Informant John E Stalling
(b) Address 1727 Abbottston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 3147 E Pratt St

OCT 16 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1945 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1943 to Oct 15 1945 and that I last saw h[illegible] alive on Oct 15 1945.

Immediate cause of death: Metastatic Carcinoma of Lung from Breast.
Due to
Due to
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation July 20 1943
Major findings of operation: Carcinoma of Breast.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J B Stevens M.D.
Address 3400 Eastern Ave Date signed 10/16/45

VS 150

G33274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G33274
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 E. Belvedere Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 E. Belvedere Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Naomi Durham

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-2275

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29-1895

8. AGE: Years 49 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Examiner

11. Industry or business Strauss-Baer Co.

FATHER
12. Name John P. Durham
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Leach
15. Birthplace Maryland

16 (a) Informant Mrs. George L. Blaney
(b) Address 836 E. Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Falls Road

19 (a) Date received by local registrar OCT 16 1945 (b) Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14- 1945, at 2:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1945 to Oct 14 1945 and that I last saw him alive on Oct 1 1945

Immediate cause of death: Respiratory Failure — Duration 3 days

Due to: Metastatic Carcinoma including Carcinoma of Breast — 6 Months 1 yr.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Louis F. O'Donnell

Address 7301 York Rd Baltimore 4 Md. Date signed Oct 16 1945

G33275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46B ✓ Registered No. G33275

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 E 33rd St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 E 33rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Harry E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1-1874

8. AGE: Years 71 | Months 1 | Days 13 1/2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name James Schultz
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Hart
15. Birthplace Ireland

16 (a) Informant Mary E. Hanson
(b) Address 719 Register Ave Lauder

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Rd

18 (a) Funeral director John C. Moran
(b) Address 3000 E. Baltimore

OCT 16 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1943, to Oct. 13 1945, and that I last saw her alive on Oct. 12 1945.

Immediate cause of death: Chronic myocarditis — Duration 5 year
Chronic glomerulonephritis
Due to Hypertensive C V Renal disease
Due to Terminal uremia
Other Conditions: Chronic hypertrophic arthritis
Carcinoma stomach (cell type not stated)
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harlold M.D.
Address 4706 Harford Road Date signed 10/13/45

VS 150

1312

633276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 633276

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 4302 PK. Hgts. Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MORRIS OBERSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie Oberstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Jeweler

11. Industry or business

FATHER 12. Name Mendel Oberstein

13. Birthplace Russia

MOTHER 14. Maiden Name Bertha —

15. Birthplace Russia

16 (a) Informant Fannie Oberstein

(b) Address 4302 PK. Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1739 E. Balto. St.

19 (d) OCT 16 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1945 at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1945 to 10/15 1945 and that I last saw h alive on 10/15 1945.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Myocardial infarction	
Due to Coronary thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Hamburger M.D.

Address Sinai Hospital Date signed 10/15/45

VS 150

633277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 633277

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2804 Loudon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Loudon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BONNIE JEAN ROBERTSON

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	none	F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1945

8. AGE: Years	Months	Days	If less than one day
-	5	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Lester G. Robertson
13. Birthplace Rocky Point, Va.

MOTHER
14. Maiden Name Margaret J. Varina
15. Birthplace Balto., Md.

16 (a) Informant Mr. Lester G. Robertson
(b) Address 2804 Loudon Ave. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 16 1945 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1945, to Oct 15 1945 and that I last saw h[illegible] alive on Oct. 15 1945.

Immediate cause of death	Duration
Myocardial Failure	
Due to Bronchial Pneumonia	
Due to Paralysis chest, throat, cause Unknown	8/7/1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Harmon M. D.
Address [illegible] Date signed 10/15/45

VS 150

(over)

63278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No. 63278

HB #80957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 0 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1889

8. AGE: Years	Months	Days	If less than one day
56	0	18 17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Schaefer
13. Birthplace Maryland

MOTHER
14. Maiden Name Susanna Hochadel
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4436 Belair Road

18 (a) Funeral director Edgar W. Carlson
(b) Address 724 E. Eager St.

OCT 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1945 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 14, 1943 to Oct. 11, 1945, and that I last saw him alive on Oct. 11, 1945.

Immediate cause of death	Duration
cardiac failure	
Due to Hypertension cardiovascular disease	
Due to	
Other Conditions Nephrolithiasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 756 Date signed 10/16/45

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633679 Vomberg 633679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address O'Sullivan Bldg.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captain Paul J. Vomberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1886

8. AGE: Years	Months	Days	If less than one day
59	9	26	hr. min.

9. Birthplace Estonia Germany (Town, county, and state)

10. Usual Occupation Capt

11. Industry or business Mooring Mate

FATHER
12. Name John Vomberg
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant John Graham
(b) Address 1221 Park Ave New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location New York

18 (a) Funeral director Leo D. Cook
(b) Address 170-03 N Park Park Ave

Oct 16 1945 (Date received by registrar) (By) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 10-15-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

633280
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Dowling

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4 Sex MALE | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 21 1865

8. AGE: Years 79 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B. O. R. R.

FATHER
12. Name Thomas Dowling
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Brohgan
15. Birthplace Ireland

16 (a) Informant Howard E. Dowling
(b) Address 232 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 1945
(month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location City

18 (a) Funeral director B. H. Watters
(b) Address Pratt & Strecker Sts

19 (Date received) OCT 16 1945
Hunting for Wilkinson, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14th 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Oct 14 1945
and that I last saw h alive on Oct 14 1945

Immediate cause of death Myocarditis — Duration

Due to Generalized arteriosclerosis — 10 yrs

Due to Carcinoma of Prostate — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan M. D.
Address 24 N. Fulton Ave Date signed 10/15/45

X

G33281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G33281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 St. Stephens St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 St Stephens St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur B. Callahan

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-01-3715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Mary A. Callahan
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	24	hr. min.

9. Birthplace Farnham, Richmond Co, Va.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Channing Callahan
13. Birthplace Va.

MOTHER
14. Maiden Name Victoria Callahan
15. Birthplace Va.

16 (a) Informant Mrs Mary A. Callahan
(b) Address 1614 St. Stephens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Frederick Rd

18 (a) Funeral director Frederick A. Ode
(b) Address 1200 N. Lombard St

19 (a) OCT 16 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1945 to 10/14 1945
and that I last saw him alive on 10/14 1945.

Immediate cause of death Carcinoma of lung (rt)

Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Mella M. D.
Address 2030 Wilkens Date signed 10/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633682

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13B

633682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Kiebking

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Joseph Kiebking
6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8 - 1894

8. AGE: Years	Months	Days	If less than one day
51	-	5	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Nicholas Dittmar
13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Funk
15. Birthplace Md.

16 (a) Informant Joseph Wiebking
(b) Address 346 S. Stricker St -

17 (a) Burial (b) Date thereof 10-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 16 1945 Huntington Williamsville, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-13 1945; at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 10/13 1945.
and that I last saw h alive on 10/12 1945.

Immediate cause of death Pulmonary Oedema — Duration 2 days
Due to Cerebral Hemorrhage — 10 Hrs
Due to
Other Conditions Tuberculosis — 4 Yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kenneth Katzenberger M.D.
Address 711 Medical Arts Bldg Date signed 10/15/45

X Katzenberger

3 T 1688-83

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1720C

Registered No. 633283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. East Ave. Road, Box 533
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Joseph B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1921

8. AGE: Years	Months	Days	If less than one day
24	4	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah E. Ackerman
15. Birthplace Md.

16 (a) Informant Alfreida Scott
(b) Address East Ave. Chase Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25/45 (month) (day) (year)
(c) Cemetery or crematory Sharp St. Cemetery
Location Chase Md.

18 (a) Funeral director Mrs. Robert A. Elliott Jr.
(b) Address 1129 N. Caroline St.

19 (a) OCT 16 1945 (Date received by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1945, at 9 45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural and Subarachnoid Hemorrhage, Traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-13-45 at 6 25 P. M. Balto Co.
(b) Where did injury occur? Eastern Ave. & Earl's Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian Struck by auto

23. Signature Robert E. Sutton M.D.
Medical Examiner.
Date signed Oct 14 1945

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

633284 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 E. preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 E. Preston St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Cordelia Patterson
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race C
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife D. Patterson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 1872
8. AGE: Years 72 Months 11 Days 14 If less than one day hr. min.
9. Birthplace Gloucester Co, Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name George Ward
13. Birthplace Va
MOTHER 14. Maiden Name Martha Olmond
15. Birthplace Va
16 (a) Informant Martha Daly
(b) Address 1220 E. preston St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Co. Md.
18 (a) Funeral director Albert E. Wilson
(b) Address 1515 McElderry
19 (a) Oct 16 1945 (b) Date received by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945 at 11 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1945 10/14 1945 and that I last saw h[illegible] alive on 10-14 1945
Immediate cause of death Cirrhosis of liver
Duration 12 mos
Due to nephritis
Due to Arterio-sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jas R. Blake
Address 1327-H Eutaw St Date signed 10/16/45

VS 150

G35285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. 38285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3127 Cliftmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Same Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Bayne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Bayne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1882

8. AGE: Years	Months	Days	If less than one day
63	7	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Brakeman
11. Industry or business B & O R.R.

FATHER
12. Name Wm. C. Bayne
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McDonald
15. Birthplace Ireland

16 (a) Informant Elizabeth Bayne
(b) Address 3127 Cliftmond Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director John A. Miller
(b) Address 2053 Jefferson St.

OCT 16 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct. 15 1945, and that I last saw h[im] alive on Oct. 1 1945

Immediate cause of death Cerebral Hemorrhage
Due to Arteriosclerosis + Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Silvia L. Levy
Address 3122 Fontaine Place Date signed 10/15/45

633286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

633286

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 George Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victoria Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-'45

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER	12. Name	Melvin Howard
	13. Birthplace	Maryland
MOTHER	14. Maiden Name	Annette Wilson
	15. Birthplace	Maryland

16. (a) Informant Annette Wilson
(b) Address 605 George Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Wm. A. Jackson
(b) Address 916 Pennsylvania Avenue

19 (a) (Date received by registrar) OCT 16 1945 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1945, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Edema of brain
Dehydration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed 10-16-45.

G33687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33687

Registered No. 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Mt. Airy (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Ruth Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13 1938

8. AGE: Years	Months	Days	If less than one day: hr.	min.
6	11	2		

9. Birthplace San Francisco, Cal. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Geo. C. Anderson
13. Birthplace Cal.

MOTHER
14. Maiden Name Alice Noonan
15. Birthplace Iowa

16 (a) Informant Mrs. Alice Noonan
(b) Address Mt. Airy, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director C. J. Gramm & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) Date received (Registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1945, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Oct 15 1945, and that I last saw her alive on Oct 15 1945.

Immediate cause of death	Duration
Intraventricular hemorrhage	
Due to Acute lymphatic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Acute lymphatic leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard S. Hemmy, Jr. M. D.
Address University Hosp. Date signed 10/17/45

X

G333588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G333588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Thames St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Pauline Rewieska or Barishin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1896

8. AGE: Years	Months	Days	If less than one day
49 ?			hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Vetka
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run, Md. A.G.C.

18 (a) Funeral director John A. Shebianka Jr.
(b) Address 423 S. Patapsco St. Washington Boulevard

16 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945, to Oct. 14 1945, and that I last saw her alive on Oct. 14 1945.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to	
Due to	
Other Conditions Tr. Meningitis & Cyanosis. Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Dorn M. D.
Address 4940 Eastern Ave Date signed 10-15-45

VS 150

X

REMARKS: WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

633489 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 S. Binney St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LEWIS JOSEPH KAHL

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
World War 2	215-13-6130	Male	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1920

8. AGE: Years	Months	Days	If less than one day
25	0	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Amer. Smelting & Ref. Co.
11. Industry or business

FATHER
12. Name Christian F. Kahl
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Agnes May Price
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. C.H. Kahl - brother
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10- -45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS,
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) By Huntington Williams, M.D. Registrar

16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1945, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 AM at 10-14-45 M.
(b) Where did injury occur? 3044 Hudson St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas Burners on, but unlit

23. Signature Howard J. Masters M.D. Medical Examiner.
Date signed 10-15-45

X 128

G33490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a G33490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Light St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur Cowman

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-10-8510

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Mary A. Cowman
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	8	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Bookkeeper
11. Industry or business: L.A. Sandlass Advl

FATHER
12. Name: George W. Cowman
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Mary H. Durkee
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Mary Cowman
(b) Address: 510 N. Highland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Cem.
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) OCT 16 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 19[illegible], at 11 24 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Sutton M.D.
Medical Examiner.
Date signed Oct. 16 1945

VS 151 Huntington Williams, M.D.

Cancer age is especially important. Physicians: please write the causes of death clearly and legibly.

G33291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G33291 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6515 Sefton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6515 Sefton Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Virginia Amrein

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-05-8712

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elwood L. Amrein
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Sept. 29th, 1908

8. AGE: Years 37 | Months 0 | Days 15 | If less than one day: Hr. ###### min. ######

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Farm Bureau of Maryland

FATHER
12. Name Charles E. Myers Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alma B. New
15. Birthplace Virginia

16 (a) Informant Elwood L. Amrein (Husband)
(b) Address 6515 Sefton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 16 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14th., 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Oct 14 1945, and that I last saw h[illegible] alive on Oct 4 1945.

Immediate cause of death: Coronary thrombosis — Duration D.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature Laurel L. Amrein M. D.

Address 1261 E North Ave Date signed 10-17-45

X

633692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

633692

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Ridgecroft Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Ridgecroft Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard N. Bush

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-10-9949

4. Sex Mal | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara M. Bush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1882

8. AGE: Years 63 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Chauffer Delivery

11. Industry or business Truck

FATHER 12. Name John Bush
13. Birthplace Balto.

MOTHER 14. Maiden Name Josephine Miller
15. Birthplace Balto.

16 (a) Informant Clara M. Bush
(b) Address 4010 Ridgecroft Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 17 45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location Balto.

18 (a) Funeral director Philip Hesing Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1sd 6, 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1945, at 5 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1945 to 10/14 1945, and that I last saw h,m alive on 10/14 1945.

Immediate cause of death Myocardial Failure — Duration 3 days

Due to Hypertension Cardio-Vascular Renal disease & Endocarditis — Duration years?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. L. Bayley M.D.
Residence 4010 Ridgecroft Rd. Date signed 10/15/45 M. D.

X

G33293 G33293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 ~~East~~ University Parkway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Lyon Shriver
3 (b) If veteran, name war
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 29, 1872

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	—	16		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name William Shriver
13. Birthplace Maryland

MOTHER
14. Maiden Name Roberta Lyon
15. Birthplace Maryland

16 (a) Informant Miss Ethel Rufus Shriver
(b) Address Lyon Home Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans Sons Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) (Date rec'd by registrar) (b) Huntington, West Virginia

OCT 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1945, at 1:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1945, to Oct 15 1945, and that I last saw h-r alive on Oct 15 1945.

	Duration
Immediate cause of death Toxemia — peritonitis	
Due to Ruptured appendix — peritonitis	16 days
Due to	
Other Conditions Appendicectomy	

(Include pregnancy within 3 months of death)
Date of operation Sept 29
Major findings of operation: Ruptured appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Milton Linthicum M. D.
Address Mercy Hosp. Date signed 10/15/45

X

48195 G33c94

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 12 d

G33c94 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Homestead
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. 2 - Box 460
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lunnie Lee Claggett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-43

8. AGE: Years 2 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Fla.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Elliott K. Claggett
13. Birthplace Md.

MOTHER 14. Maiden Name Valda Lowery.
15. Birthplace Mo.

16 (a) Informant Reeda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/45 (month) (day) (year)

(c) Cemetery or crematory
Location Homestead, Fla.

18 (a) Funeral director John D. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

19 (a) (b) Registrar
Date received OCT 16 1945 Lexington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-16- 1945 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-14 1945 to Oct-16 1945 and that I last saw h[illegible] alive on Oct-16 1945:

Immediate cause of death: Cardiac failure

Due to: Cardiac decompensation

Due to: ? cystic fibrosis of Hd pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Blair Emmett Watson
Asst Jr Resident
Address Johns Hopkins Hospital Date signed 10/16/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 633295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 80 days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Hanover - (Rural) (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT PAUL NEIDERER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Geraldine Neiderer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/1917

8. AGE: Years 28 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Paul C. Neiderer
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Blanch McKinnon
15. Birthplace Pennsylvania

16 (a) Informant Paul Neiderer
(b) Address Hanover Rubal #4

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 19 45 (month) (day) (year)
(c) Cemetery or crematory Conewago Adams Co. Pa.
Location

18 (a) Funeral director W. A. Reiner
(b) Address Hanover, Pa.

19 (a) Date received OCT 16 1945 (b) Registrar Huntington Mills, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16, 1945 at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1945 to Oct 16 1945, and that I last saw h[illegible] alive on Oct 14 1945.

	Duration
Immediate cause of death Carcinomatosis	3 mo
Due to Carcinoma of head of pancreas	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-12-45

Major findings of operation: Carcinoma of pancreas & metastasis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Liphardt M. D.
Address Union Memorial Hosp. Date signed 10-16-45

VS 150

X

B-36

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. 6336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5866 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5866 Belair Road
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3. (a) FULL NAME George Robinson McClary, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Isabelle M. Stewart
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 6, 1870

8. AGE: Years	Months	Days	If less than one day
75	7	9	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ---

FATHER
12. Name George M. McClary
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary E. Chestnut
15. Birthplace Baltimore, Maryland

16 (a) Informant George R. McClary, Jr.
(b) Address 5866 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b) Huntington for Williams, M.D.
Date received OCT 18 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-1945 at 3.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3-1930 to 10-15-1945, and that I last saw him alive on 10-14-1945

Immediate cause of death Chronic myo-endo-carditis — Duration Unknown
Due to unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Sybert M. D.
Address 2802 Harford Rd Date signed 10-16-45

X

VS 150

63329 7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√ 46 M

Registrar's No. 63329 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts

(c) Hospital or institution: Mercy Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 211 E Chase Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Mary McGrath Durkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Chas R. Durkin. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	3	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Thomas McGrath

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary B. Tuley

15. Birthplace Ireland

16 (a) Informant Mrs. Mary A. Durkin

(b) Address 211 E Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 4th & Fayette Sts

18 (a) Funeral director J. J. Tobey & Sons

(b) Address 318 Light St.

19 (a) (b) Huntington, West Virginia

Oct 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1945, at 6.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1945, to Oct. 15 1945, and that I last saw h[illegible] alive on Oct. 15 1945.

Immediate cause of death	Duration
Myocarditis	5 months
Due to	
Due to	
Other Conditions Uremia, Cardio-Renal Insufficiency, Senility	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. [illegible] M.D.

Address Mercy Hospital Date signed 10/15/45

VS 150

G33298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G33298 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 N. Pulaski St.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 4
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK PAUL MILLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-09-3892

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Emma A. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Motorman
11. Industry or business Baltimore Transit Co.

FATHER
12. Name August Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kunkle
15. Birthplace Germany

16 (a) Informant Mrs. Emma A. Miller
(b) Address 2115 N. Pulaski St.

17 (a) Burial (b) Date thereof 10/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 17 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14, 1945, at 7:15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Oct. 14 1945 and that I last saw [illegible] alive on Oct. 13 1945

Immediate cause of death: Coronary thrombosis — Duration: 1/4 hr

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Feasenmyer

Address 1402 E. Lanvale Date signed 10-16-45

X

G33299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

G33299 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hampton Court Apt.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton Court Apts. Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lenerd H. Harrington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Abrahams
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 12, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Elisha Harrington
13. Birthplace

MOTHER
14. Maiden Name Sallie
15. Birthplace Wilmington, Del.

16 (a) Informant Mrs. Margaret A. Harrington
(b) Address Hampton Court Apt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) [illegible] by [illegible] Huntington Williams, Mgr.

OCT 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to Oct 15 1945
and that I last saw him alive on Oct 15 1945

Immediate cause of death Coronary Thrombosis
Due to Arterio Sclerosis Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Immediate death Gradual

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M F Headey, M.D.
Address 1403 Park Ave Date signed 10/16/45

X

G33300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

G33300 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 Woodlawn Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 Guilford Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Chesnut Stockton.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Jessie Stockton.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	2	5	hr. min.

9. Birthplace Baltimore.
(Town, county, and state)
10. Usual Occupation Insurance
11. Industry or business Broker

FATHER
12. Name Richard Stockton
13. Birthplace Pa

MOTHER
14. Maiden Name Harriott Grant
15. Birthplace South Carolina

16 (a) Informant Mrs Jessie Stockton
(b) Address 3207 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17th (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2095 Pleasant St

19 OCT 17 1945 (Date received by registrar) Huntington Willemse, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16th 1945, at 2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1945 to Oct 16 1945 and that I last saw h~~e~~r alive on Oct. 16, 1945.

Immediate cause of death Cerebral hemorrhage — Duration 2 days.
Due to Arteriosclerosis. — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Greytan M.D.
Address 3963 Greenmount Ave Signed 10/16/45

VS 150

X

633301

BALTIMORE CITY HEALTH DEPARTMENT

CWK-96421

CERTIFICATE OF DEATH 132

633301

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days

(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1100 W. Fayette Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grant Ulysses Bullock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1875

8. AGE: Years	Months	Days	If less than one day
70	6	13	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace ?

MOTHER

14. Maiden Name Lucy (Surname unknown)

15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Annapolis Ave Westport

18 (a) Funeral director Hardesty & Lowe

(b) Address 502 N. Howard Street

19 (a) OCT 17 1945 (Registered by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1945, to Oct. 14 1945, and that I last saw h im alive on Oct. 14 1945.

Immediate cause of death	Duration
Cardiac arrest + pulmonary edema + uremia	
Due to Hypertension 7 yrs + kidney infection (chronic)	
Due to Fail to empty. Blockage ? Prostate Bladder	
Other Conditions uremia	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Eugene Abram Patemillet M. D.

Address B. C. H. Date signed 10-15-45

VS 150

G33502
4822013

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1119a

G33502
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1150 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-45

8. AGE: Years	Months	Days	If less than one day
	2 1	20	hr. min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name [illegible] Clement Glenn
13. Birthplace S. C.

MOTHER
14. Maiden Name Mattie [illegible]
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10 17 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) (Date received by registrar) OCT 17 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 17 1945 at 4:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1945 to Oct. 17 1945, and that I last saw her alive on Oct. 17 1945.

Immediate cause of death [illegible] Pulmonary Tuberculosis — Duration 310 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

633603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3105 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Fleet Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elva M. Lancaster

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Married

6 (b) Name of husband or wife William A. Lancaster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8 1909

8. AGE: Years	Months	Days	If less than one day
35	11	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name William Shank
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Jessie Welch
15. Birthplace W. Virginia

16 (a) Informant (H) William A Lancaster
(b) Address 3105 Fleet Street

17 (a) Burial (b) Date thereof Oct. 19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nethecan Hill, Elk Garden,
Location Blaine West Virginia

18 (a) Funeral director Lilly and Zeiler Inc
(b) Address 403 South Wolfe Street

19 (a) OCT 17 1945 (b) Registrar
(Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1945 to 10/14 1945 and that I last saw h[illegible] alive on 10/13 1945

Immediate cause of death	Cerebral Hemorrhage	Duration
Due to	Hypertension	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature 3215 Eutaw Pl Charles Flax M. D.
Address Date signed

X

G33504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G33504 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2341 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Tom E. Wright,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	13	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Seamstress,
11. Industry or business

FATHER
12. Name Thomas Robinson
13. Birthplace ?

MOTHER
14. Maiden Name Eliza Stubbs.
15. Birthplace Gloucester Co. Va.

16 (a) Informant Tom Wright.
(b) Address 2341 Druid Hill Ave.

17 (a) Burial (b) Date thereof Oct 21, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Co. Md.

18 (a) Funeral director Geo. Lowry & Son Maryland
(b) Address 1651 Druid Hill Ave.

19 (a) OCT 17 1945 Filed by Worthington for Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15- 1945; at 1:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1- 1945, to 10-15- 1945, and that I last saw her alive on 10-15- 1945.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Pneumonia.	2 days
Due to Cancer of Body of Uterus.	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank E. Worthington M. D.
Address 2340 Madison Ave. Date signed 10-15-45

VS 3

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 633305

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 706 N. Milton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Melvin Jerscheid

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-1488

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Sophie Fishpaugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1901

8. AGE: Years	Months	Days	If less than one day
43	9	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business E.T.Newell & Company

FATHER
12. Name Adam Jerscheid
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Cunzeman
15. Birthplace Baltimore, Md.

16 (a) Informant Charles Jerscheid- brother
(b) Address 706 N. Milton Avenue

17 (a) Burial (b) Date thereof 10/19/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

OCT 17 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1945 11:15 P.M.

21. I certify that I took charge of the remains described above, held an ~~expectation~~ Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fulbright M.D.
Medical Examiner.
Date signed 10/16/45

X

AB-71502 G33306

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G33306

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs-8mos-16days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Balster or Rose Balster

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ----

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph Balster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1863

8. AGE: Years 82 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John White (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Frannie or Fannie (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto, Md.

18 (a) Funeral director Philip Brandt Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 17 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15- 1945 at 11.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29- 1942, to 10-15 1945, and that I last saw her alive on 10-15- 1945.

	Duration
Immediate cause of death Uremia + Cardiac arrest	
Due to Gangrene of Extremity	
Due to Diabetes Mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Abrahamson M.D.
Address B C H Date signed 10-16-45

X

PRESS WHITE PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33.07 X G33.07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Chester (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Larry Elliot Douglas ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-[illegible]

8. AGE: Years	Months	Days	If less than one day
—	11	10	hr. min.

9. Birthplace Chester S. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name James Douglas.
13. Birthplace Chester, S.C.
14. Maiden Name Margaret Douglas
15. Birthplace Chester, S.C.

16 (a) Informant Margaret Douglas.
(b) Address 615 N. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 - [illegible]45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. William
(b) Address 322 N. Schroeder St.

19 (a) OCT 17 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1945; at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1945, to 10-15 1945, and that I last saw h[illegible] alive on 10-15 1945.

Immediate cause of death Dehydration and intoxication — Duration 16 days
Due to Diarrhea
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 10-16-45

633608 BALTIMORE CITY HEALTH DEPARTMENT 46B Registration No. 633608

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1571 Lanvale ln
(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1571 Lanvale ln (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jallie Austin

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Lee Austin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1901

8. AGE: Years	Months	Days	If less than one day
44	5	18	hrs. min.

9. Birthplace Washington, N. C. (Town, county, and state)
10. Usual Occupation Shop Keeper
11. Industry or business Store

FATHER
12. Name Hayward Gilmore
13. Birthplace Ayden, N. C.

MOTHER
14. Maiden name Hyatt
15. Birthplace Washington N. C.

16 (a) Informant Lee Austin
(b) Address 1571 Lanvale ln

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams

OCT 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/45 19 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/45 to 10/16/45, and that I last saw him alive on 10/16/45

Immediate cause of death: Coronary Thrombosis — Duration 5 min.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lee Ellis M. D.
Address 727 Madison Date 10/17/45

VS 46

633.09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 633.09

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1303 N. Montford Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1303 N. Montford Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Frank U. Trautman

3 (b) If veteran, name war World War # 1

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Trautman

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept-5-1888

8. AGE: Years 57 | Months 1 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Globe Brewery

FATHER 12. Name Frederick F. Trautman

FATHER 13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Farren

MOTHER 15. Birthplace Balto Md.

16 (a) Informant Margaret Trautman

(b) Address 1303 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Mem

Location North Ave

18 (a) Funeral director John F. Melly Inc

(b) Address 2435 E. Oliver St

19 (a) 10/17/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1945 to 10/16 1945, and that I last saw him alive on 10/10 1945.

Immediate cause of death: Advanced Bilateral Pulmonary Tuberculosis — Duration: 3 yrs?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Karl Grossman M. D.

Address 1212 N. Patterson Date signed 10/17/45

Please X

VS 150

633.510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

Registered No. 633.510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3601 Gough St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLA L. DICE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
--	215 - 12-3501	Female	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1902.

8. AGE: Years	Months	Days	If less than one day
43	4	25	hr. min.

9. Birthplace Thomas, W.Va.
(Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business Restaurant

FATHER
12. Name William Dice
13. Birthplace Illinois

MOTHER
14. Maiden Name Elvia McCroby
15. Birthplace Aurora, W.Va.

16 (a) Informant Robert T. Dice (Brother)
(b) Address 604 S. Bouldin St.

17 (a) Burial (b) Date thereof 10 - 17 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave. Rd. Balto., Co.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) 10 17 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1945 at 8:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1945 to Oct 14 1945 and that I last saw her alive on Oct 14 1945

Immediate cause of death Uraemia Coma — Duration 10/10/45

Due to Chr Parenchymatous Nephritis — 4/45

Due to Chr Myocarditis — 4/45

Other Conditions — prev

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Richardson M.D.
Address 801 N Kenwood Ave Date signed 10/16/45

G33311 ✓ G33311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 Greenhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4147 Eierman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard A. Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Bertha A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21 - 1909

8. AGE: Years	Months	Days	If less than one day
36	8	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name August J. Kramer
13. Birthplace Hartford Co. Md.

MOTHER
14. Maiden Name Elizabeth Zinkand
15. Birthplace Germany

16 (a) Informant Mrs. Bertha Kramer
(b) Address 4147 Eierman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Reuck
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Williams, M.D. Registrar

OCT 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28-1945 to 10-16-1945, and that I last saw living alive on 10-15-1945

Immediate cause of death: Acute nephritis — Duration: 18 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred B. Sybert M. D.
Address 7807 Harford Rd. Date signed 10-17-45

VS 150

Please write plainly, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33512

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G33512
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Greene Sts
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte (Lottie) Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joshua Boyd Hayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	28	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name James Roberts
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Kelly
15. Birthplace

16 (a) Informant Mrs Frank Smith
(b) Address 1613 N. Bond St.

17 (a) Burial (b) Date thereof 10-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md

18 (a) Funeral director Leonard J. Rusch
(b) Address 5345 Harford Rd.

19 (a) OCT 17 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1945, at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1945 to 10-16 1945, and that I last saw h~~as~~ alive on 10-16 1945.

Immediate cause of death	Duration
Lobar pneumonia	
Due to Bronchopneumonia	
Due to Acute tracheitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Specimen of Lung
of autopsy Dilated Heart, Pneumonia & edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. W. Buchanan M. D.
Address West Baltimore General Hosp. Date signed 10-16-45

X

633513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

633513
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Helwig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Annabelle Helwig
6 (c) If alive, give age 1884 years

7. Birth date of deceased (mo., day, yr.) Oct 26 1884

8. AGE: Years	Months	Days	If less than one day
60	11	21	hr. min.

9. Birthplace Detroit Mich
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Annabelle Helwig
(b) Address 216 W Fayette St

17 (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bells National
Location Frederick Rd

18 (a) Funeral director Oder Funeral Home Inc
(b) Address 4644 York Rd,

19 (a) (b)
(Date received by Registrar) (Registrar)

OCT 17 1944

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1944, at 12 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection / Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. P. Lubowski M.D.
Medical Examiner.
Date signed 10/18/44

(over)

633514 BALTIMORE CITY HEALTH DEPARTMENT 633514
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST
(c) Hospital or institution: SINAI HOSPT
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) VR YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 N. SMALLWOOD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Scherr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife HARRY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name ISRAEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-17-45 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL. RD + HAMILTON AVE

18 (a) Funeral director Jack Lewis Jr.
(b) Address 1439 E. Balto St.

OCT 17 1945 (a) Date received by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1945 to 10-16 1945, and that I last saw her alive on 10-11 1945.

Immediate cause of death	Duration
Myocard infarct + Pulmonary edema.	
A.S.H.D. (Arteriosclerotic Heart Disease)	
Due to) uremia.	
Due to Hypertrophic Fibrosis.	
Due to Bronchopneumonia.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fernall Patt M. D.
Address Sinai Hosp Balt. Md Date signed 10-16-45

VS 150

G33315 ✓ G33315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 111c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Warner St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 71
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Warner Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Deal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1935

8. AGE: Years 10 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Leo. Sewell
13. Birthplace Md

MOTHER 14. Maiden Name Bernice Deal
15. Birthplace Md

16 (a) Informant Bernice Deal
(b) Address 1116 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilcox
(b) Address 1000 Brantley Ave

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1945 - 3:30 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Marked emaciation and dehydration.
Due to Malnutrition.

Other Conditions Edema of lungs, moderate.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 10-15-45

VS 151

X

G33316 BALTIMORE CITY HEALTH DEPARTMENT G33316
Registered No.

CERTIFICATE OF DEATH 157a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Herbert Travers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1945

8. AGE: Years	Months	Days	If less than one day
	6	17	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Herman Travers
13. Birthplace md

MOTHER
14. Maiden Name Margaret Martin
15. Birthplace N. C.

16 (a) Informant Margaret Travers
(b) Address 38 S. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Hartley Ave

19 (a) 10 17 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1945, at 1 P. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic adhesive meningitis, hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 10-15-45

VS 151

Space is especially important. Physicians: please write the causes of death clearly and legibly.

G33517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G33517 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Greenway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winfield Scott Cahill
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence E. Cahill
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): November 2, 1861
8. AGE: Years 83 | Months 11 | Days 13 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business

FATHER
12. Name: John Cahill
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden Name: Mary Ann Gallagher
15. Birthplace: Baltimore, Md.

16 (a) Informant: Florence E. Cahill (wife)
(b) Address: 3809 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn, Md.

18 (a) Funeral director: Flynn & Fleming
(b) Address: 1426 Light Street

(a) OCT 17 1945 (Date received by Registrar) (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 15, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9-45 19 to 10/15 1945.
and that I last saw h alive on 10/15 19 45

Immediate cause of death: Acute Coronary thrombosis — Duration: 2 days
Due to:
Due to:
Other Conditions: Chronic Nephritis, Cardio Vascular disease
(Include pregnancy within 3 months of death)
Date of operation: X
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Luther E. Leatherman, M.D.
Address 10 W Madison St Date signed 10/17/45

VS 150

633518 ✓ 633518

633518
HB#96365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Jackson Hezekiah

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years	Months	Days	If less than one day
63?			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Hezekiah
13. Birthplace Va.

MOTHER
14. Maiden Name Jane Anderson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave;

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore City

18 (a) Funeral director Jos. G. Kelson
(b) Address 1303 Preston St.

19 (a) (Date issued by registrar) (b) Huntington Williams, M.D. Registrar

Oct 17 1945

Vs 750

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1945, 8:45PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1945, to Oct. 12, 1945 and that I last saw him alive on Oct. 12, 1945.

Immediate cause of death Lobar pneumonia — Duration 5 da.
Due to
Due to
Other Conditions Uremia — 3 da.
Hypertensive Cardiovasc. dis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Davis M. D.
Address 4940 Eastern Ave Date signed 10/16/45

X

633519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 633519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 Lee St
(c) Hospital or institution: South Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Belle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME O'DELL JOHN S.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Emma J. O'Dell
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 7-1858

8. AGE: Years	Months	Days	If less than one day
86	10	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benjamin O'Dell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. George Hoile (daughter)
(b) Address 3709 Belle Ave, Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.
18 (a) Funeral director G. Howard Strong
(b) Address 3107 W. North Ave.
19 (a) (Date received by Local Registrar) (b) Registrar

OCT 17 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1945, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1945, to Oct 16 1945, and that I last saw him alive on Oct 16 1945.

Immediate cause of death	Duration
Bronchopneumonia	1 Week
Due to	
Due to	
Other Conditions Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Madison Blagden III M. D.
Address South Balt. Gen. Date signed Oct 17 1945

X Howard

633520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

633520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3027 Sheel ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Sheel ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Joseph Griffith

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-1967

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Sheeran Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/75

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	3	9		

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Dyer Dept.
11. Industry or business Laundry Dyer

FATHER
12. Name Edward Gunnan
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna McGraw
15. Birthplace Ireland

16 (a) Informant Mrs Ed Kahoe
(b) Address 3027 Sheel ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Lexington Rd

18 (a) Funeral director J. Staley Sons
(b) Address 3 E Eight St

19 (a) OCT 17 1945 (Date rec'd by registrar) Registrar

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1945, at 4:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1941 to Oct 16 1945
and that I last saw her alive on Oct 14 1945.

Immediate cause of death Carcinoma Cecum.

	Duration
Due to	
Due to	
Other Conditions Hypertensive Cardio Vascular Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A B Stevens M.D.
Address 3400 Eutaw Pl Date signed 10/17/45

VS 180

633321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 93D

633321 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Bloomingdale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Bloomingdale Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Sparks

3 (b) If veteran, name war: ***
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel A. Sparks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1858

8. AGE: Years 87 | Months 8 7 | Days 23 | If less than one day: hr. min.

9. Birthplace: Queen Anns Co. Md. (Town, county, and state)
10. Usual Occupation: House-wife
11. Industry or business

FATHER
12. Name: Wm. H. Seward
13. Birthplace: Queen Anns Co. Md.

MOTHER
14. Maiden Name: Mary Godwin
15. Birthplace: Queen Ann Co. Md.

16 (a) Informant: Miss. Minnie D. Sparks
(b) Address: 1208 Bloomingdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Balto. Co. Md.

18 (a) Funeral director: Robert S. Little
(b) Address: 2700 Edmondson Ave.

19 (a) (Date received by registrar) (b) Registrar

OCT 17 1945 Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH: Oct. 17 1945 at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936, to Oct. 17 1945, and that I last saw her alive on Oct. 16 1945.

	Duration
Immediate cause of death: Cerebral thrombosis	2 weeks
Due to: Arteriosclerotic cardio vascular disease	10 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Phus E Reed M.D.
Address: 3629 Edmondson Ave. Date signed 10/17/45

G33522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G33522 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 E. Poultney St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 31 E. Poultney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Frederick William Gehren

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Henry G. Gehren
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah R. Meyers
15. Birthplace Md

16 (a) Informant Miss Elsie D. Gehren
(b) Address 31 E. Poultney St.

17 (a) Burial (b) Date thereof 10/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John F. Kenny Inc
(b) Address 715 Light St.

19 (a) Date received by Registrar Registrar

OCT 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/13/45 19 at 10 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Oct 1945, and that I last saw him alive on 10-13-45 19

Immediate cause of death Terminal from bronchopneumonia of both lower lobes

Due to Emaciation

Due to Edema - (since about patient was one year age)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. D. Zapple M. D.
Address 642 Wash Blvd Date signed 10-16-45

Huntington Williams, M.D.

X

G333523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. G333523

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 91
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Leach.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma Leach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871.

8. AGE: Years 74 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired Watchman

11. Industry or business

FATHER
12. Name Michael Leach
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Leach
15. Birthplace Ireland

16 (a) Informant Christina Moore
(b) Address 1921 Oak Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Cty

18 (a) Funeral director Mary J. M. Shufeldt
(b) Address 1400 Eutaw & Lanvale

(a) (Date rec'd by registrar) OCT 18 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16/45 19 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1945 to 10/16 1945, and that I last saw h alive on 10/16 19 45

Immediate cause of death Cardiac Respiratory failure

Due to Debilitation

Due to Cerebrum Rectus segment

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Patrick Jamison M.D.
Address 1 Professional Bldg Date signed 10/16/45

VS 190

G33324
AB-79088

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
93 D

G33324 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs-9mos-5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1750 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Eckelman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1858

8. AGE: Years	Months	Days	If less than one day
87	3	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Sweart Eckelman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schneiby
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 10-19-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16- 1945, at 9.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-11- 1945, to 10-16 1945 and that I last saw h. er alive on 10-16 1945.

Immediate cause of death Cardiac failure — Duration Date.

Due to Arteriosclerotic heart disease — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Bacon M. D.
Address 4940 Eastern Date signed 10-17-45

633525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ 633525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. 3110 Tamar Blvd (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME FRIEDA FELDMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Benj.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Alex Fehreben

13. Birthplace Russia

MOTHER 14. Maiden Name Lash

15. Birthplace Russia

16 (a) Informant Hoyt Resch

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)

(c) Cemetery or crematory Beth Shalom Memorial Park

Location Woodlawn Md

18 (a) Funeral director Jack Levin

(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) (b) Williamsport Md

OCT 18 1945 Hunting for

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1945 to 10/17 1945 and that I last saw h[illegible] alive on 10/17 1945

Duration

Immediate cause of death Myocardial insufficiency

Due to Massive infarction of myocardium

Due to Coronary thrombosis or embolism

Other Conditions Arteriosclerosis

Various veins c thrombophlebitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Daniel Hamburger M. D.

Address Sinai Hospital Date signed 10/17/45

X

633326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43B

633326 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sigmund Feinblatt

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillie J Feinblatt
6 (c) If alive, give age ~~xx~~ years

7. Birth date of deceased (mo., day, yr.) Feb 12, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	4	hr. min.

9. Birthplace Halifax N. S.
(Town, county, and state)
10. Usual Occupation Nursing Home owner
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Halifax N. S.

MOTHER
14. Maiden Name Cohen
15. Birthplace Halifax N. S.

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Wingate Well Rd
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1945 at 7:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1945 to 10/16 1945 and that I last saw h ~~m~~alive on 10/16 1945.

Immediate cause of death	Duration
Heart failure	
Due to arteriosclerotic heart disease & pulm. edema	
Due to	
Other Conditions Carcinoma of tongue with metastases to Neck	

(Include pregnancy within 3 months of death)
Date of operation 8/15/45
Major findings of operation: metastatic carcinoma of tongue in neck
of autopsy: Carcinoma of tongue, with [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman Rudo M. D.
Address Sinai Hosp. Date signed 10/16

VS 150 OCT 18 1945 Huntington Williams, M.D.

G33527 ✓ G33527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Dukeland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Dukeland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Hassig

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business

FATHER
12. Name Wolf
13. Birthplace Russia

MOTHER
14. Maiden Name Shafa
15. Birthplace Russia

16 (a) Informant Wife
(b) Address D

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt & Hamilton Ave

18 (a) Funeral director Jas. Lewis Sons
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 OCT 18 1945 Huntington Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-45 19 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1945 to 10-17 1945 and that I last saw h. alive on 10-17 1945

Immediate cause of death Cerebral Hemorrhage — Duration 1 hr

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benedict Shekerdie M.D. X

Address 1201 Poplar Grove St Date signed 10-18-45 M. D.

633528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

633528

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 812 W. Lexington St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Balto, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 812 W Lexington
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1886

8. AGE: Years	Months	Days	If less than one day
59	9	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name William Chester

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Katie Brown

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elsie Chester

(b) Address 812 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) (Date filed by registrar) OCT 18 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15-45 19 , at 3:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11-45 19 , to 10-15-45 19 , and that I last saw him alive on 10-15 19 45.

Immediate cause of death Respiratory failure

Due to Cerebro-Vascular accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Richard A. Horner M. D.

Address Univ. Hospital Date signed 10-15-45

VS 160

X

G33529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1574

Registered No. G33529

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Cookesie St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Bocklage

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1945

8. AGE: Years	Months	Days	If less than one day
			2 hr. 35 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Bocklage
13. Birthplace

MOTHER
14. Maiden Name Margaret Roberts
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret Bocklage
(b) Address 1414 Cookesie St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 18 45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Balto. Md.

18 (a) Funeral director George A. Farley
(b) Address Fayette & Fulton Ave

OCT 18 1945 (b) Huntington Ave Baltimore, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945 at 12M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Oct 17 1945 and that I last saw him alive on Oct 16 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Monstrosity - Syn-opthalmus	2½ hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Milton Lothrain M. D.
Address Mercy Hosp. Date signed 10/17/45

VS 150

X

633330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 633330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lily Gourd Lily W. Gourd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arthur P. Gourd
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) January 6, 1890

8. AGE: Years	Months	Days	If less than one day
55	9	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick W. Herman
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Berger
15. Birthplace Germany

16 (a) Informant Mrs Janet Kirby
(b) Address 1814 Sulgrave Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Ellis Funeral
(b) Address 4510 Liberty Heights Ave.

OCT 18 1945 (Date received by Registrar) Hunting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945 at 1.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to 19 , and that I last saw h.r alive on Oct 16 19 45

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebrovascular hemorrhage	18 hrs.
Due to Hypertension & arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. M. Campbell M. D.
Address Maryland Gen Hosp Date signed 10-16-45

Approved: Hugh R. Caldwell M.D. Chas C. Fetter M.D.

VS 180

G33.531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G33.531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Winston Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine E. Kussmaul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Howard E. Kussmaul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	16	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Samuel J. Hook
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Mary Hooker
15. Birthplace Baltimore County, Md.

16 (a) Informant Mr. Howard E. Kussmaul
(b) Address 901 Winston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director
(b) Address 4510 Liberty Heights Ave.

19 (a) OCT 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945 at 5 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 7 1945 to Oct 16 1945 and that I last saw her alive on Oct 16 1945.

Immediate cause of death: Cancer of Thymus Gland

Duration: 10 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest W. Kalus

Address 1735 Poplar Grove St. Date signed 10/16/45

633332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. 633332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 E Lombard St. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME George P. Dausch Sr.

3 (b) If veteran, name war: No.
(c) Social Security Account No. 219-07-9387

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Matilda
6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Oct. 12 1875

8. AGE: Years: 70 | Months: | Days: 3 | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation: Furniture finisher

11. Industry or business: Md. Store Fixture Co.

FATHER
12. Name: Charles Dausch
13. Birthplace: Balto

MOTHER
14. Maiden Name: Anna Michel
15. Birthplace: Balto

16 (a) Informant: Matilda Dausch
(b) Address: 1817 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 18 45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: 4300 Belair Rd

18 (a) Funeral director: Martin D. La Angelica
(b) Address: 37 S. Ann St.

OCT 18 19 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH October 15, 1945, at 9 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said (Autopsy, Inspection or Inquiry) Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracerebral hemorrhage right hemisphere — Spontaneous

Due to

Other Conditions Skull fracture (non contributory.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D. Medical Examiner.
Date signed 10-16-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33.333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. 3498

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Madison Ave
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Madison Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fred S. May

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Mary May

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 27, 1895

8. AGE: Years	Months	Days	If less than one day
50	5	19	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Maid Carrier

11. Industry or business Federal

FATHER
12. Name Samuel May
13. Birthplace N. C.

MOTHER
14. Maiden Name Flora Howren
15. Birthplace N. C.

16 (a) Informant Lester May
(b) Address 124 Church St. Thomasville N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-45 (month) (day) (year)

(c) Cemetery or crematory Thomasville N. C.
Location N. C.

18 (a) Funeral director George H. Nelson
(b) Address 1303 Presstman St

OCT 18 1945 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 — 16 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 — 16 — 1945 to 10 — 16 1945, and that I last saw h[illegible] alive on 10 — 15 — 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	unknown
Due to Apposma + Low resistance	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 129 N. Stricker St Date signed 10-18-45

X

633334

BALTIMORE CITY HEALTH DEPARTMENT 4/61 Registered No. 633334

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1342 E. Fremont (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Boyd
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-22-97
8. AGE: Years 47 | Months 9 | Days 25 | If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name ?
FATHER 13. Birthplace Va
MOTHER 14. Maiden Name Betty Taylor
MOTHER 15. Birthplace Va
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location 2nd & Fulton
18 (a) Funeral director Geo. H. Kelson
(b) Address 1300 Walbrook Ave
OCT 18 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1945 at 4 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Oct 16 1945
and that I last saw her alive on Oct 16 1945

	Duration
Immediate cause of death: Uremia	4 days
Due to Nephrosclerosis	unknown
Due to Hypertensive Cardiovascular Disease	years
Other Conditions Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Maxwell Williams M. D.
Address Johns Hopkin Hospital Date signed 10-17-45

131a

VS 150

633335

BALTIMORE CITY HEALTH DEPARTMENT ✓ 633335
CERTIFICATE OF DEATH 46a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o. information should be carefully supplied. correct age is especially important. Physicians: please write the cause.s of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 W. 20th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph White
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1891

8. AGE: Years	Months	Days	If less than one day: hr.	min.
53	10			

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Joseph White
13. Birthplace Va.

MOTHER
14. Maiden Name Fannie
15. Birthplace Va.

16 (a) Informant Annie White
(b) Address 103 W 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

OCT 18 1945 (Date rec'd by registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Oct 13 1945, and that I last saw him alive on Oct 13 1945.

Immediate cause of death	Duration
Auricular Fibrillation	
Due to Toxicity & G-I obstruction	
Due to Ca of Esophagus c widespread Metastases	
Other Conditions Pulm. edema Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Ca of Esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Osmund Wiesner M. D.
Address Univ. Hosp. Date signed 10-13-45

VS 150

633536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

633536 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Block Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Norman Ave. C.T.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Ida L. Fisher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Henry M. Fisher
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown/87

8. AGE: Years	Months	Days	If less than one day
74	-	-	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mr. ? Cohan
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs Lena Grossfeld
(b) Address 3301 Norman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) OCT 18 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1945, at 7:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1945, to 10-18 1945, and that I last saw h.e.r. alive on 10-17 1945.

Immediate cause of death	Duration
Metastatic Carcinoma (Primary)	
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Hawkins Jr M.D.
Address Union Memorial H Date signed 10-18-45

VS 150

X

633537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

633537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Noble St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. C
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia A. Griffner

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-2784

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Adolph Griffner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1888

8. AGE: Years 57 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Sewing Machine Operator

11. Industry or business

FATHER
12. Name Valentine Beickwich
13. Birthplace Balto.

MOTHER
14. Maiden Name Sophia Hinold
15. Birthplace Balto.

16 (a) Informant Mrs. Sophia McElroy
(b) Address 340 Noble St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 20 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Aliceanna St

19 OCT 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1945, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-45 19 to 10-17-45 19, and that I last saw h alive on 10-17-45 19.

Immediate cause of death Acute Heart Failure — Duration 1 day

Due to Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John Costantini M.D.
Address 225 Conkling Date signed 10-19-45

VS 150

X

633538 Martinez ✓ 633538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Thames St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Thames St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Spain

3 (a) FULL NAME Cipriano Martinez

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Spain (town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Ship

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Jesse Rodriguez
(b) Address 1700 Thames St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 45 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Ellicott City Md

18 (a) Funeral director Feilly & Zeller Inc.
(b) Address 403 S Wolfe St.
(c) Huntington for Williams, M.D.

OCT 18 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1945 at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1945 to Oct 17 1945, and that I last saw h[illegible] alive on Oct 16 1945.

Immediate cause of death Chr Pulmonary Tuberculosis — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon M.D.
Address 134 S. Bway Date signed 10/19/45

VS 150

G33339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G33339 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 W. Fairmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 W. Fairmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Blue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1877

8. AGE: Years	Months	Days	If less than one day
68	—	20	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Daniel Blue
13. Birthplace Md

MOTHER
14. Maiden Name Katie Blue
15. Birthplace Md.

16 (a) Informant Eugene Blue
(b) Address 1040 W. Fairmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elgin O. Wilson
(b) Address 1000 Bradley Ave

OCT 18 1945 (a) (Local Registrar) Huntington Hilliard, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1945, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1945, to 10/16 1945, and that I last saw h[illegible] alive on 10/16 1945.

Immediate cause of death Pneumonia
Myocarditis

Due to Hypertension
Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Jamden M. D.
Address 1040 W Fairmont Ave Date signed 10/18/45

VS 180

X

G33340 Di Girolamo G33340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 33a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 E. Cross St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marion Di Girolamo ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Antonio Di Girolamo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1870

8. AGE: Years	Months	Days	If less than one day
75	5	28	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Di Nato Annacito
13. Birthplace Italy

MOTHER
14. Maiden Name Lucia Appolonio
15. Birthplace Italy

16 (a) Informant Vincenzo Di Girolamo
(b) Address 113 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elizabeth Hoyle Inc.
(b) Address 115 E. Fort Ave. Balto. Md.

19 OCT 18 1945 Date rec'd by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1945 to 10-16 1945, and that I last saw h 9 alive on 10-16 1945.

	Duration
Immediate cause of death Hypostatic pneumonia	6 days
Due to Streptococcus in lesion of throat	20 days
Due to Grippe	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Emanuel M. D.
Address Medical arts Bldg Date signed

VS 150

X

G33341 ✓ G33341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 121a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Spence st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie E Duvall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Mary Land (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name — Metzger
13. Birthplace —

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant W E Duvall
(b) Address Bergan Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/45 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cemetery
Location Brunkhorst Md

18 (a) Funeral director Edward Hamborn
(b) Address 2319 West Nash

19 OCT 18 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1945 at 4.30 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aortic incompetency due to calcification

Due to

Other Conditions Arteriosclerosis, chronic nephritis, edema of brain & lungs.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 10-17-45

VS 151

92a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633542 Within Limits

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

633542 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Budda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
About	55			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Ann O'Brien
(b) Address 911 St Paul St.

17 (a) Funeral (b) Date thereof 10 20 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Tilburys Co
(b) Address 1217 Park Ave

19 (a) OCT 18 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

15

20. DATE OF DEATH October 14, 1945 at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions Arteriosclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 14 1945 at 4:1 A.M.
(b) Where did injury occur? Found in Lot of 612 E. Baltimore St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury Fall?

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed Oct. 15 1945

VS 151

X

Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G33343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G33343
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. LANVALE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1896

8. AGE: Years	Months	Days	If less than one day
49	3	27	hr. min.

9. Birthplace Smithfield, W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Friend B. Frances
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha Rose
15. Birthplace Unknown

16 (a) Informant Sol Francis
(b) Address 1135 Guilford Ave

17 (a) Removal (b) Date thereof 10-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Summit Memorial
Location Clarksburg, W. Va.

18 (a) Funeral director Pollard Funeral Home
(b) Address 1217 St Paul St

19 (a) Date received by registrar Huntington Williams
OCT 18 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1945, at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shiterelis M.D.
Medical Examiner.
Date signed 10-18-45

G33344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33344 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 N Charles St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Ommen, Ferdinand

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6. Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gertrude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7 1893

8. AGE: Years 52 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Pharmacist

11. Industry or business

FATHER
12. Name Ferdinand Ommen
13. Birthplace Germany

MOTHER
14. Maiden Name Alma Wittington
15. Birthplace Maryland

16 (a) Informant Alma Ommen
(b) Address 3706 N Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Middletown
Location Middletown Md

18 (a) Funeral director Tilhom Cook Co
(b) Address 2104 Pont St

1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18, 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19— to Oct 18, 1945, and that I last saw him alive on Oct 18, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension Cerebrovascular Disease

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bobby E. Lewis M. D.
Address Franklin Sq. Hosp. Date signed 10/18/45

G33345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G33345 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lafayette & John St.

(c) Hospital or institution: Hospital for the Woman of Maryland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs. 3 mo. 22 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town ~~Baltimore~~ Ruxton
(If outside city or town limits, write RURAL and give town)

(d) Street No. ~~Roland Avenue~~
(If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Helen Ruth Zinn (Zinn)

3 (b) If veteran, name war: N

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry T. Zinn

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 6/25/1920

8. AGE: Years	Months	Days	If less than one day
25	3	22	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER

12. Name Karl W. Schmidt

13. Birthplace Baltimore, Maryland

MOTHER

14. Maiden Name Helen T. Schmidt

15. Birthplace Baltimore, Maryland

16 (a) Informant Karl Schmidt

(b) Address Baltimore Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director Wilbur Cook Inc

(b) Address 1219 E Fort St

19 (a) ..... (b) Huntington Williams, M.D. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1945, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1945, to 10/17 1945, and that I last saw her alive on 10/17 1945.

Immediate cause of death: acute glomerulonephritis — Duration: 3 mo

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: acute glomerulonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) ..... (County) ..... (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature J. Richard Compton M. D.

Address Hospital for Woman Date signed 10/17/45

633546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111a

633546

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Eutaw St.

(c) Hospital or institution: South Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)

(d) Street No. 455 Ilchester Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME MILLER, CONRAD W.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Hattie Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1881

8. AGE: Years	Months	Days	If less than one day
64	5	7	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Meat - cutter

11. Industry or business

FATHER

12. Name Edward Miller

13. Birthplace Pennsylvania

MOTHER

14. Maiden Name Eliza Rumble

15. Birthplace Pennsylvania

16 (a) Informant Mrs Hattie Miller

(b) Address 455 Ilchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood Gdns

Location Parkville, Balto Co.

18 (a) Funeral director Wm Cole Inc

(b) Address 1217 St Paul St

19 (a) 10-18-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/45 to 10/17/45 and that I last saw him alive on 10/17 1945.

Immediate cause of death Pulmonary Embolism — Duration 2 days

Due to

Due to

Other Conditions Buerger's disease — 1 YR.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pulmonary Embolism

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo E Wheeler

Address South Balto Gen Hosp Date signed 10-17-45 M. D.

X

G33547 BALTIMORE CITY HEALTH DEPARTMENT G33547
CERTIFICATE OF DEATH 929
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Scott St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda F Moore.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Samuel K
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1872

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	2	16		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fitch Ludlam
13. Birthplace

MOTHER
14. Maiden Name Lillie Snow
15. Birthplace

16 (a) Informant Nathan K Moore
(b) Address 612 E 38th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory London Town
Location Baltimore Md

18 (a) Funeral director Nathan Lockie
(b) Address 1317 E Lanvale St

1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1945 at 1/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to Oct 17 1945, and that I last saw h/e alive on Oct 12 1945.

Immediate cause of death Coronary thrombosis

Duration
one day

Due to Chronic myocardial + endocardial disease with cardiac hypertrophy and congestive failure

Duration
several years

Due to generalized arteriosclerosis with hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Michie M. D.
Address 290 E Edmondson Ave Date signed Oct 17 1945

VS 150

X

Duke to Mrs. Hearn

348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 633348

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Page ... Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Broadmoor Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Broadmoor Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK P. WOHNLICH

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret M. Wohnlich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 15, 1875

8. AGE: Years 70 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace: Detroit, Mich. (Town, county, and state)

10. Usual Occupation: Eastern Manager

11. Industry or business: Parke-Davis Co.

FATHER
12. Name: Lewis Wohnlich
13. Birthplace: Basle, Switzerland

MOTHER
14. Maiden Name: Louise Fitz
15. Birthplace: London, England

16 (a) Informant: Mr. B. Franklin Hearn
(b) Address: 312 Broadmoor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) ... (b) ... Huntington Williams, M.D.

OCT 18 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1945, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1945, to 19..., and that I last saw him alive on 10/16 1945.

Immediate cause of death: Coronary thrombosis

Due to: Arterioscleratic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: acute; 8-10 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Edward Leach, M.D.

Address 14 E. Eager St. Date signed 10/18/45

X

633349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

633349 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 Sorrento Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Sorrento Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Christine Fritze

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Fritze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 26, 1869

8. AGE: Years 76 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town or county, and state)

10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Antone Zimmerman
13. Birthplace Maryland

MOTHER
14. Maiden Name Friederika Mueller
15. Birthplace Germany

16 (a) Informant Mr. Frank Fritze
(b) Address 106 Sorrento Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Shepard
(b) Address 2101 Frederick Ave.

19 (a) [illegible] (b) Date [illegible] Huntington Williams, M.D.

OCT 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1945 at 1:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to Oct 16 1945 and that I last saw h.e.r. alive on Oct 16 1945.

Immediate cause of death	Duration
Arterio-sclerotic heart disease	6 mos.
Due to	
Due to	
Other Conditions Hypertension	

Atrophy Arteriolar
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Callen M. D.
Address 3321 Frederick Ave Date signed 10-17-45

X

G33550 HD #96708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
64 ?	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Taylor Fuller
13. Birthplace Md.

MOTHER 14. Maiden Name Florence Campbell
15. Birthplace 350 E Biddle St.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Adolph Hotel
18 (a) Funeral director 968 Druid Hill Ave
(b) Address
OCT 19 1945 (Date rec'd by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945 at 7:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1945 to Oct. 17, 1945 and that I last saw h er alive on Oct. 17, 1945.

Immediate cause of death	Duration
congestive heart failure	
Due to hypostatic cardio-vascular lesion	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 10/18/45

VS 150

X

633651
AB-96194

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 633651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. Stevenson Ct. Turners Station (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Girl Richmond-Twin 'A'

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21-1945

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Richmond
13. Birthplace S.C.

MOTHER
14. Maiden Name Viola Young
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Dastrup Ref

18 (a) Funeral director
(b) Address

OCT 19 1945 (b) Huntington Williams, Mgr.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 23- 19 45 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1945 to 9-23 19 45, and that I last saw h alive on 9-23- 19 45

Immediate cause of death Prematurity

Due to

Due to

Other Conditions Born Home
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Baylis M. D.
Address Balt City Hosp Date signed 9-24-45

VS 150

G33352

JL - 96195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G33352

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 B. Stevenson Ct. Turners Sta.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Richmond (Viola) Twin 'B'

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1945

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Richmond
13. Birthplace S. C.

MOTHER
14. Maiden Name Viola Young
15. Birthplace S. C.

16 (a) Informant B. C. H. records
(b) Address 4940 Eastern Ave.

17 (a) 3:32 P.M. (Burial, cremation, or removal) (b) Date thereof 10-11-45 (month) (day) (year)
(c) ~~Cemetery~~ or crematory 4940 Eastern Ave
Location Balto City Hosp

18 (a) Funeral director
(b) Address

19 (a) OCT 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1945 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21 1945 to Sept. 21 1945 and that I last saw her alive on Sept. 21 1945.

Immediate cause of death Prematurity — Duration 2 hrs.

Due to

Due to

Other Conditions Born Home

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Bayliss M.D.
Address Balt. City Hosp. Date signed 10-7-45

VS 150

G33353

AB-95638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G33353

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos 13days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 413 N. Caroline St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23- 1945

8. AGE: Years	Months	Days	If less than one day
	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Norfleet
13. Birthplace N.C.

MOTHER
14. Maiden Name Bernice Johnson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) 3 30 P.M. (Burial, cremation, or removal) (b) Date thereof 10-14-45 (month) (day) (year)

(c) [redacted] crematory
Location Baltimore City Hosp

18 (a) Funeral director.
(b) Address 4940 Eastern Ave

19 (a) Date received 10-19-1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-16- 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23- 1945 to 10-6 1945, and that I last saw her alive on 10-6- 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Diarrhea	4 days
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. M. Morrison Jr. M. D.

Address City Hosp. Date signed 10/15/45

VS 150

633.354

HKP #96370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

633.354

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 10-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Hours

(e) Length of stay in Baltimore (yrs., mos., or days) 8 Hours

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1412 E. Madison St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Harley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1945

8. AGE: Years	Months	Days	If less than one day
			8 hr. 2 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Oscar Harley

13. Birthplace ?

MOTHER

14. Maiden Name Catherine Davis

15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records

(b) Address 4940 Eastern Avenue

17 (a) 3 30 P.M. (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)

(c) Cemetery or crematory

Location Baltimore City Hosp

18 (a) Funeral director

(b) Address 4940 Eastern Ave

19 (a) OCT 19 1945 (Date received by Registrar) Huntington Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1945 at 4:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29, 1945 to Sept. 30, 1945 and that I last saw him alive on Sept. 30, 1945

Immediate cause of death

Due to Cerebral meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at A M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. D.

Address B.C.H. Date signed 10-16-45

VS 150

G33355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33355
Registered No.

MD 95517

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7301 Bayfront Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-9-45

8. AGE: Years	Months	Days	If less than one day:
	1	16	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William A. White

FATHER 13. Birthplace N. C.

MOTHER 14. Maiden Name Grace Daggarly

MOTHER 15. Birthplace N. C.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) 2:32 P.M. (Burial, cremation, or removal) (b) Date thereof 10-16-45 (month) (day) (year)
(c) Cemetery or crematory
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Hosp
(b) Address

19 (a) OCT 19 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 19 45 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9- 1945 to 9-24- 1945 and that I last saw her alive on 9-24- 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Diarrhea & vomiting	6 days
Due to	
Other Conditions jaundice	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Morrison, Jr. M. D.
Address City Hospital Date signed 9/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

633356
JL - 95577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 633356

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 N. Patterson Park Ave (Or other description of location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Shawver - Barbara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1945

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Shawver
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Mohr
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) 3 30 P.M. (Burial, cremation, or removal) (b) Date thereof 10-15-45 (month) (day) (year)

(c) ~~Cemetery or~~ crematory
Location 4940 Eastern Ave

18 (a) Funeral director Balto City Hosp
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 19 45 at 9:48 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 19 45 to Aug. 22 19 45 and that I last saw her alive on Aug. 22 19 45

Immediate cause of death Prematurity — Duration 12 days

Due to

Due to

Other Conditions Diarrhea, Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Baylouth, M.D. M. D.
Address Balt City Hosp Date signed 10-23-45

VS 150

G33357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G33357

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 N. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lassen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 10/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location

University Medical School OCT 18 1945

18 (a) Funeral director Malphus Halstead Commissioner of Health
(b) Address 918 Druid Hill Ave

19 OCT 19 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1945, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertensive Degeneration

Due to

Other Conditions Pulmonary Tbc

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. P. Lubinski M.D.
Medical Examiner.

Date signed 10/5/45

VS 151

F 3009

G33358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Short Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Spears

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-45

8. AGE: Years	Months	Days	If less than one day
			13 hrs. min.

9. Birthplace Balto. md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wade Spears
13. Birthplace Florence S.C.

MOTHER
14. Maiden Name Eunice wearing
15. Birthplace Florence S.C.

16 (a) Informant Eunice Spears
(b) Address 1210 Short Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7- 1945, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1945, to 10-2 1945, and that I last saw her alive on 10-7 1945.

Immediate cause of death

Due to prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Bunnell M. D.

Address 121 Augusta St Date signed 10-16-45

F 3014 X

633559 BC-G 34481 633559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Royce Ave (15) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bass

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-45

8. AGE: Years	Months	Days	If less than one day
			12 hrs min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Elliot Bass
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Bass
15. Birthplace Cleveland, Ohio

16 (a) Informant Mrs Rose Bass
(b) Address 3408 Royce Ave (15)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) (b) Harrington for Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1945, to 10-15 1945, and that I last saw h/m alive on 10-15 1945.

Immediate cause of death Respiratory Failure — Duration 12 hrs.

Due to Premature 28 weeks

Due to 2 lbs. 10 oz.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Baby Bass M. D.
Address Franklin Sq. Hosp. Date signed 10-16-45

3013 X

G33360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V119a

Registered No. G33360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Mount Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Davis ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-45

8. AGE: Years	Months	Days	If less than one day
0	2	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arrie Davis
13. Birthplace Hamlet, S.C

MOTHER
14. Maiden Name Mary Wilson
15. Birthplace Sumter, S.C.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 16 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1945 at 5:19 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1945 to 10-13 1945, and that I last saw her alive on 10-13 1945.

Immediate cause of death: Acute Gastro interitis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature V. Cadle Jones M.D.
Address 1131 Harlem Ave Date signed 10/19/45

VS 150

F 3012

X

633661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 633661

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 E. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Dean Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 18, 1945

8. AGE: Years	Months	Days	If less than one day
		15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Hudson
13. Birthplace Ohio

MOTHER
14. Maiden Name Marcelle Diers
15. Birthplace Minnesota

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1945, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from September 18 1945 to October 3 1945, and that I last saw him alive on October 3 1945.

Immediate cause of death prematurity — Duration
? aspiration atelectasis
? intracranial hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Usborne M. D.
Address Johns Hopkins Hosp. Date signed 10-4-45

VE 180

F 3011

X

633362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √159

Registered No. 633362

PRESS WHITE PRINTING, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: The Johns Hopkins Hospital 5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1404 Mc Elderry Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred Jacobs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1945

8. AGE: Years	Months	Days	If less than one day
		2	12 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edgar Johnson
13. Birthplace

MOTHER
14. Maiden Name Mary Jacobs
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 16 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1945, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from September 30 1945, to October 2 1945, and that I last saw him alive on October 2 1945.

Immediate cause of death prematurity
atelectasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.

Address Johns Hopkins Hosp. Date signed 10-4-45

VS 150

3010

X

633563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

633563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 Witherspoon Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Witherspoon Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte B Strohmeyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife John F. Strohmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 - 1873

8. AGE: Years	Months	Days	If less than one day
72	2	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Geo Baker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hall
15. Birthplace Baltimore

16 (a). Informant Carl F. Strohmeyer
(b) Address 8212 North View Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19th (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Merrick Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

VS OCT 19 19 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1945; at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Oct. 16 1945 and that I last saw her alive on Oct 15 1945.

Immediate cause of death Myocarditis — Duration yrs
Due to Arteriosclerosis Generalized — yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry L. Hynson M. D.
Address 20 E Preston St Date signed 10/17/45

X

G33364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33364
Registered No.

HB 96269

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 North Bond St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Czeckoslavakia

3 (a) FULL NAME
Mike Loconis or Laconia?

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ?

8. AGE: Years	Months	Days	If less than one day
63?			hr. min.

9. Birthplace Czeckoslavakia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pete Loconis or Laconis?
13. Birthplace Czeckoslavakia

MOTHER
14. Maiden Name Annie?
15. Birthplace Czeckoslavakia

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) (Signature) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 19 45 at 5:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 19 45 to Oct. 7 19 45, and that I last saw him alive on Oct. 7 19 45

Immediate cause of death Uremia,
renal failure of remaining kidney

Due to Operative absence of left kidney

Due to Renal lithiasis?
nephrosclerosis?

Other Conditions multiple hemorrhagic phenomenon

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Hoveland M. D.

Address 1546 Date signed 10/16/45

3017

X

G333365

HEP #86319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G333365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
45-1 & 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) East
(d) Street No. 1004 Essex Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Burice

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Snyder
13. Birthplace Md.

MOTHER
14. Maiden Name Katherine Muchmon
15. Birthplace ?

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1945, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27, 1945, to Sept. 29 1945, and that I last saw her alive on Sept. 29, 1945.

Immediate cause of death	Duration
generalized debility	
Due to Arteriosclerosis	
Due to Ca of cervix	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Brown Pettorillet M. D.
Address BCH Date signed 10-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3016

Pettorillet X

G33366
HEP #53579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33366
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 -7 - 1 26
(e) Length of stay in Baltimore (yrs., mos., or days) 84 -7 - 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. No home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 3, 1861

8. AGE: Years	Months	Days	If less than one day
84	7	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10th 1945 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 9, 1940, to Oct. 10, 1945, and that I last saw her alive on Oct. 10, 1945.

Immediate cause of death Lobar pneumonia — Duration 3 da.

Due to

Due to

Other Conditions Hypertensive Cardiovas. dis. Diabetes ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave. Date signed 10-16-45

VS 150

3015

108

G33367

BALTIMORE CITY HEALTH DEPARTMENT

HB#94950

CERTIFICATE OF DEATH ✓46E

Registered No. G33367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Balto City Hosp 4→1
Baltimore Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Sharp St. (The Friendly Inn) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Rooney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	15 13	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Rooney(d)
13. Birthplace Europe

MOTHER
14. Maiden Name Maria Doland
15. Birthplace Mass.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave.(Records)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 19 1945 (Date rec'd by registrar) (b) Thurston for Hilleary, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1945, at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23, 1945, to Oct. 8, 1945, and that I last saw him alive on Oct. 8 1945.

Immediate cause of death Acute Hemorrhage Duration
Intestinal

Due to

Due to

Other Conditions Ca of Sigmoid + general carcinomatosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Abrahamson M. D.
Address BCH Date signed 10/18

VS 150

F 3018 × CATONSVILLE 85

G33368

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

G33368 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address, 1773 Homeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1773 Homeland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** W. Harry F. Herwig

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2106

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lyda C. Herwig

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) January 22 1881

8. AGE: Years 64 | Months 8 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Ship carpenter

11. Industry or business Armored Corp.

FATHER
12. Name Henry Herwig
13. Birthplace unknown

MOTHER
14. Maiden Name Lena Gassmann
15. Birthplace Md

16 (a) Informant Lyda C. Herwig
(b) Address 1773 Homeland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20. 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Mrs. John H. Deufel & Son
(b) Address 801 W. Lafayette Ave.

19 (a) (Date received by local registrar) OCT 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1945 to Oct 17 1945. and that I last saw h[illegible] alive on Oct 17 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 hrs
Due to Arterio Sclerosis & Hypertension	6 mo
Due to Chronic Interstitial Nephritis	6 mo
Other Conditions Carcinoma Stomach	1 mo

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Stevens M. D.
Address 2878 Harford Ave Date signed 10 18 45

VS 150

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G333369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 9 → 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT AUGUST KIRSCHKE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 219-01-5316

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena F. D. Krischke

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1867

8. AGE: Years 78 | Months 8 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Piano Maker

11. Industry or business S.S. Reed

FATHER
12. Name John Kirschke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Lena Kirschke
(b) Address 1841 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22, 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) OCT 19 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18, 1945 at 1 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945, to Oct. 18 1945.
and that I last saw him alive on Oct. 18 1945.

Immediate cause of death Cardiac Failure
bronchopneumonia, F peripheral
Circ. collapse

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 9/7/45

Major findings of operation: Benign prostatic hypertrophy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. F. Rothenberg
Address Sinai Hosp. Date signed 10/8/45
M. D.

Samuel Rothenberg X

VS 150

G33370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G33370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Pfeifenberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/30/1880

8. AGE: Years	Months	Days	If less than one day
65	4	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Michael Pfeifenberger

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Rosa Pfeifenberger

MOTHER 15. Birthplace New York

16 (a) Informant None

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 18 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 19 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1945, to 10/7 1945, and that I last saw him alive on 10/7/45 19

Duration

Immediate cause of death Circulatory Collapse - with possible Pulmonary embolism

Due to Cardiac decompensation due to aortic insufficiency also Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Bailey M. D.

Address Mercy Hosp. Date signed 10/7/45

VS 150

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X

633571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 633571

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 S. Eutaw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Obelia Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 18 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5- 1945 at 7.50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Chronic pulmonary tuberculosis with cavities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Malleis M.D.
Medical Examiner.

Date signed 10-5-45

[3020 X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G33372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33372 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Michael L. Gumbleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	15	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Catholic Priest

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rev. James
(b) Address 1130 N. Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Washington D. C.

18 (a) Funeral director Martin Fisher & Sons
(b) Address 1827 N. North Ave. Huntington Williams, Md.

19 OCT 19 1945 (b) Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease.
Due to (probable coronary occlusion).

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. (Medical Examiner)
Date signed 10-17-45

633373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 633373

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2309 EDMONDSON AVE.

(c) Hospital or institution: ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days) 10YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) 2

(d) Street No. 2309 EDMONDSON AVE. (If rural give location)

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country ✓

3 (a) FULL NAME CARRIE P. SHER

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. NONE

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JOHN V. SHER

(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) JAN 20-1865

8. AGE: Years 80 Months 8 Days 28 If less than one day hr. min. ✓

9. Birthplace WILMINGTON, DEL. (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER

12. Name ANDREW WILDE

13. Birthplace MASS.

MOTHER

14. Maiden Name HANNAH STEVENS

15. Birthplace NEW ENGLAND

16 (a) Informant JOHN V. SHER

(b) Address 2309 EDMONDSON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 20 45 (month) (day) (year)

(c) Cemetery or crematory GLENWOOD CEM.

Location WASHINGTON, DC.

18 (a) Funeral director C. LESTER WEBER

(b) Address 2503 EDMONDSON AVE.

19 (a) (Date received by Registrar) OCT 19 1945 Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945, to Oct 18 1945.

and that I last saw h alive on Oct 17 1945.

Immediate cause of death: Carcinoma of stomach

Due to: Metastatic cardiovascular disease

Duration: 2 yrs. 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert J. Rhodes M.D.

Address 2302 Edmondson Ave Date signed 10/19/45

VS 180

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33374

HER 496578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Stricker St., Zone 23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva May Lynch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age ~~30~~ 1887 Nov. 30 1887
7. Birth date of deceased (mo., day, yr.) ~~Sept. 30, 1885~~

8. AGE: Years	Months	Days	If less than one day
57 ~~88~~	~~9~~ 10	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Storke
13. Birthplace Md.

MOTHER
14. Maiden Name Katie Coleman
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Issue (Burial, cremation, or removal) (b) Date thereof 10, 19, 45 (month) (day) (year)
(c) Cemetery or crematory Lakmont
Location Lakmont Md.

18 (a) Funeral director Wilson Lee Inc
(b) Address 1210 E. Fayette St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1945, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1945 to Oct. 17, 1945, and that I last saw her alive on Oct. 17, 1945

Immediate cause of death
Uremia
Due to Nephrosclerosis
Due to
Other Conditions Hypertension and coronary sclerosis, arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury
23. Signature Jonathan Rowland M. D.
Address 1210 E. Fayette St. Date signed 10/18/45

(over)

X

633375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

633375
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ? (If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Elizabeth Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/14/1872

8. AGE: Years	Months	Days	If less than one day
73	5	4	hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George Schmidt
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Sharley
15. Birthplace ?

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) OCT 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1945, to Oct 18 1945, and that I last saw her alive on Oct 16 1945.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	6 yrs
Due to Chronic Nephritis	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Oct 18-45

VS 150

633576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

633576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1103 Pine Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Pine Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES CECELIA WILDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank S. Wilderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 19, 1902

8. AGE: Years 43 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace: Cincinnati, Ohio
(Town, county, and state)

10. Usual Occupation: Bookkeeper

11. Industry or business: Shoe Craft Mfg. Co.

FATHER
12. Name: Joseph F. Lipp
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Agnes A. Dierken
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Frank S. Wilderson
(b) Address: 1103 Pine Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) Lucretia Williams, Mrs. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1945, at 5 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Oct 2 1945 and that I last saw her alive on Oct. 2 1945.

Immediate cause of death: Chronic Nephritis — Duration
Due to: Pericardial Dropsy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Sellers M.D.
Address 737 W Monte Date signed 10/20/45

VS 150 OCT 19 1945 Recorded: Clarita J. Lubinsky per Roland Carter M.D.

(OVER)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. H33377

SUPPLEMENTARY (over) REPORT

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 W. Monument St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 W. Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice M. Turnmyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dr. A. C. Turnmyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1910

8. AGE: Years 35 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Fort Dodge, Iowa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Hennebery
13. Birthplace Iowa

MOTHER
14. Maiden Name Estella Spreuger
15. Birthplace Iowa

16 (a) Informant Dr. A. C. Turnmyer
(b) Address 101 W. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-45 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Baltimore, Md.

18 (c) Funeral director Wm. J. Trefmeat Son
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1945, at 12:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions Fatty degeneration of liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 10-8-45

PLEASE WRITE CLEARLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

Registered No. 633578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Coatesville R.D.#4 Penna. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANTHONY MORRIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sarah M. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1908

8. AGE: Years	Months	Days	If less than one day
37	4	5	hr. min.

9. Birthplace Odena, Pa. (Town, county, and state)
10. Usual Occupation Caretaker, State Highway
11. Industry or business State Highway Dept. of Pa.

FATHER
12. Name William Morris
13. Birthplace Pa.

MOTHER
14. Maiden Name Willa Maitland
15. Birthplace Pa.

16 (a) Informant Mrs. Sarah M. Morris
(b) Address R. F. D. #4, Coatesville, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Hephzibah Cem.
Location Coatesville, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 19 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1945 at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30, 1945 to Oct. 18, 1945 and that I last saw him alive on Oct. 18, 1945

Immediate cause of death Cardiac failure — Duration

Due to Uremia

Due to Renal shutdown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 2, 1945

Major findings of operation: Duodenal ulcer

of autopsy: Anasarca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss
Address Sinai Hospital Date signed 10/18/45

VS 150

X

G33379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33379

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 100 N. Caldwell St.

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md., (b) County Balto.

(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 507 S. Fremont Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marcellous Sauk

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0290

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Helen Sauk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/26/1878

8. AGE: Years	Months	Days	If less than one day
67	4	22	hr. min.

9. Birthplace Maryland Balto (Town, county, and state)

10. Usual Occupation Moldmaker

11. Industry or business

FATHER 12. Name John W. Sauk

13. Birthplace Balto Md

MOTHER 14. Maiden Name Amelia Knight

15. Birthplace Balto Md

16 (a) Informant Helen Sauk.

(b) Address 507 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Wash. Blvd.

18 (a) Funeral director Ambrose Dyc.

(b) Address 414 N. Franklintown Rd

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1945, at 11:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1945 to 10/18 1945, and that I last saw h[illegible] alive on 10/18 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Arteriosclerotic Cardio - Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(c) Means of injury

23. Signature Bobby L. Lewis M. D.

Address Franklin Square Hosp. Date signed 10/19/45.

633680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

633680 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of town)
(d) Street No. 1919 E. Centre St (If rural give location)
(e) Citizen of foreign country? 19 (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Fiandaca

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1916

8. AGE: Years	Months	Days	If less than one day
29			hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Fiandaca
13. Birthplace Italy

MOTHER 14. Maiden Name Concetta Carcione
15. Birthplace Italy

16 (a) Informant Angelina Fellini
(b) Address 351 E. 60th St, New York City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 22, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Queens County, New York

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date received by local registrar) Oct 19 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945, at 3:9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 17 1945 at 2:30 P.M.
(b) Where did injury occur? On street 720 S. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Shot

23. Signature Richard A. Gutierrez M.D. Medical Examiner.
Date signed Oct. 17 1945

633581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

633581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hosp.
(c) Hospital or institution: Balt., Md. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town O'Donnell Hts. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Ballard Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ralph West
3 (b) If veteran, name war
3 (c) Social Security Account No. 227-18-4645

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Cynthia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 - 1920

8. AGE: Years	Months	Days	If less than one day
25	6	12	hr. min.

9. Birthplace West Va. (Town, county, and state)
10. Usual Occupation Shipyard
11. Industry or business Beth. Steel

FATHER
12. Name George A West.
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Katie
15. Birthplace Va

16 (a) Informant Mrs. Cythia West.
(b) Address 1307 Ballard Way.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn.
Location Eastern Ave.

18 (a) Funeral director John D Connelly
(b) Address 718 Eastern ave. Balto 21

19 (a) (Date rec'd by registrar) OCT 19 1945 (b) Registrar's No.

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1945, at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1945 to 10-18-1945, and that I last saw h[illegible] alive on 10-18-1945.

Immediate cause of death	Duration
Bilat. fibrocaseous Pulmonary Tuberculosis	
Due to C Cavitation	
Due to	
Other Conditions Nephrotic Stage Chronic Glomerular Nephritis (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm A. Holbrook M. D.
Address Univ. Hosp. Date signed 10-18-45

Huntington Mfr
X

63382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 M

State Registered No. 63382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 15 Box 304 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vance Allen Stitt

3 (b) If veteran, name war

3 (c) Social Security Account No. 192-07-2105

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Merle Stitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1896

8. AGE: Years	Months	Days	If less than one day
49	4	2	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Glenn L. Martin

FATHER
12. Name William George Stitt
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Fair
15. Birthplace Pa.

16 (a) Informant Mrs. Merle Stitt
(b) Address Box 304 Route 15.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Frederick Rd.

18 (a) Funeral director John P. Connelly
(b) Address 419 Eastern Ave., Essex 21

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Carbon Monoxide

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 17, 1945 M.
(b) Where did injury occur? Essex - Md
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? N.A.
(d) Means of injury Automobile Exhaust Gas

23. Signature Howard J. Mercer M.D. Medical Examiner
Date signed 10-18-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33383 ✓ G33383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 573 Laurens St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vera Mae Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-18

8. AGE: Years	Months	Days	If less than one day
27	0	15 2/7	hr. min.

9. Birthplace Pasadena, Md (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name James M. Ratcher
13. Birthplace Charles Co, Md

MOTHER
14. Maiden Name Dora Griffin
15. Birthplace Frederick, Md

16 (a) Informant Dora Ratcher
(b) Address 573 Laurens St

17 (a) 10/20/45 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Fred. G. Kelson
(b) Address 1303 Freedman

19 (a) (b) Registrar Williams M.D.

OCT 19 1945 VS Y50

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1945, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1945 to 10-16 1945, and that I last saw h[illegible] alive on 10-16 1945

Immediate cause of death	Duration
Intestinal obstruction	
Due to Post operative adhesions	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death).

Date of operation 10-5-45

Major findings of operation: Gangrene of ileum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr WE Jones / Institute M. D.
Address 1514 Division St Date signed 10-18

X

G33384

BALTIMORE CITY HEALTH DEPARTMENT ✓ G33384

CERTIFICATE OF DEATH 832 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 w Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 w Lanvale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Craig

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	col	Divorced

6 (b) Name of husband or wife Laura
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1875

8. AGE: Years	Months	Days	If less than one day
69.	9	22	hr. min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Abraham Craig
13. Birthplace md

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Clyde Craig
(b) Address 721 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Geo. G. Kelso
(b) Address 1303 Pressman St

19 (a) (Date rec'd by registrar) (b) Filed OCT 19 1945 Huntington Williams

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Oct 17 1945, and that I last saw h alive on 10-17 1945.

Immediate cause of death Cerebral Hemorrhage

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Kershaw M. D.
Address 805 w Franklin Date signed

633385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 633385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2950 Edmondson ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2950 Edmondson ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Louise Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wm. J. Harris

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1872

8. AGE: Years 73 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Wesley Zener

13. Birthplace Pa.

MOTHER

14. Maiden Name Mary L. Arthur

15. Birthplace Pa.

16 (a) Informant Wm. J. Harris

(b) Address 2950 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19/45. (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Woodlawn, Md.

18 (a) Funeral director Harry H. Wittle

(b) Address 4101 E Edmondson ave

19 (a) (Signature of local registrar) Washington Williams, Registrar

OCT 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17/45, 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Oct 17 1945 and that I last saw h[illegible] alive on Oct 16 1945.

Immediate cause of death: Coronary Occlusion (Thrombosis) — Duration 1 hr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. P. Von Schultz M. D.

Address 4818 Edmondson ave Date signed 10/19/45

DR. - VON Schultz X

633386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. 633386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Raynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 W Mulberry (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Gee Ott (Bertha Gee (Ott))

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Gee Ott
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept-16-1873
8. AGE: Years: 72 Months: 1 Days: 1 If less than one day: hr. min.
9. Birthplace: Prussia (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none
FATHER 12. Name: Mathew Gorecka
13. Birthplace: Prussia
MOTHER 14. Maiden Name: Anna Schminska
15. Birthplace: Prussia
16 (a) Informant: Bertha G. Ott (Before death)
(b) Address: 202 W Mulberry St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-20-45 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Woodlawn
18 (a) Funeral director: Sullivan Memorial
(b) Address: 108 W Monument
19 OCT 19 1945 (Date received by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 17 1945, at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1945 to 10-17 1945 and that I last saw her alive on Oct 17 1945

Immediate cause of death: Cardiac failure
Due to: Congestive failure - Arteriosclerosis cardio vascular
Due to: Senility
Bilateral bronchopneumonia
Due to: Acute coronary thrombosis

Other Conditions: Cancer of breast 4 remedies
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
Chronic fibrosis
of autopsy: Chronic arteriosclerosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Paul C. Baldwin M. D.
Address: West Baltimore General Hosp. Date signed: 10-17-45

X

633587 6

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 66B

CERTIFICATE OF DEATH

633587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina St.
(c) Hospital or institution: Saint Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Raspe Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM A. WAHNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary E. Freburger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 1873

8. AGE: Years	Months	Days	If less than one day
72	4	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name William A. Wahner
13. Birthplace Baltimore

MOTHER
14. Maiden Name
15. Birthplace Baltimore

16 (a) Informant Son. William F.
(b) Address 102 Raspe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 - 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Frank V. Pepitone
(b) Address 2818 E. Balto St

19 (a) (Date rec'd by registrar) (b) Oct. 19 1945 Huntington — Williams Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1945 at 6 09 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1945 to Oct. 17 1945 and that I last saw him alive on Oct. 17, 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Toxaemia and acidosis	
Due to Unknown cause	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene J. Riley
Address 1400 N Carroll Date signed 10/19/45

X

G33688 (D) BALTIMORE CITY HEALTH DEPARTMENT (✓) G33688
CERTIFICATE OF DEATH 170 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lenniversity Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pasquale Rinaudo (Charles Romando)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Salvatora Brocato

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7, 1870

8. AGE: Years 75 76 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Joseph Rinaudo
13. Birthplace Italy

MOTHER 14. Maiden Name Giovanna Giglio
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 719 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Lipsitone
(b) Address 2818 E. Baltimore St

19 (a) OCT 19 1945 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1945 at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Laceration of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-10-45 at 9 10 A.M.
(b) Where did injury occur? Greene St. 2nd South of Lexington Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Benedict Skolaris M.D. Medical Examiner.
Date signed 10-18-45

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G33389 Registered No. 24747

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1044 No. Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1044 No. Eden St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Mc Nutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Married

6 (b) Name of husband or wife Harry Mc Nutt
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov 2 1889

8. AGE: Years	Months	Days	If less than one day
52	11	13 16	- hr. - min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joy
13. Birthplace

MOTHER
14. Maiden Name Frances Johnson
15. Birthplace unknown

16 (a) Informant Harry Mc Nutt
(b) Address 1044 No. Eden St.

17 (a) Burial (b) Date thereof Oct 21 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs. Robt G. Ellegood
(b) Address 1429 N. Caroline St.

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

OCT 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1945 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1945 to 10/18 1945, and that I last saw h-- alive on 10/18 1945.

Immediate cause of death Lobar Pneumonia

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rudolph Blankenship M. D.
Address 501 Perry Hill Rd Date signed 10/18/45

G33390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G33390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
So Balto. Genl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 Andre St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bauule

3 (b) If veteran, name war

3 (c) Social Security Account 2276-55-57

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Barbara Bauule
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1866

8. AGE: Years	Months	Days	If less than one day
79	7	30 29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carriage
11. Industry or business Chas Lowrey Glass Co

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Charles Bauule
(b) Address 1352 Andre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gunpowder Blvd

18 (a) Funeral director Geo H. Leyenbach
(b) Address 525 N. Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

VS OCT 19 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945 at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Carcinoma of stomach with generalized metastasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca. Stomach & metastasis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H C Reich, M.D.
Address 1213 Light St Date signed 10/18/45

633391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

633391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3918 W. 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Alcorn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1876

8. AGE: Years	Months	Days	If less than one day
69	2	29	hr. min.

9. Birthplace Maryland Penner. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business retired.

FATHER
12. Name John Alcorn
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Hershey
15. Birthplace Md

16 (a) Informant Kenneth Alcorn
(b) Address 2201 - T Place S.E Ward D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Octobr 20-45 (month) (day) (year)
(c) Cemetery or crematory St Marks
Location Highland Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md.

19 (a) [illegible] Huntington Williams, M.D. Registrar

OCT 19 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] the day stated above, and death in my opinion resulted from natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH [redacted] pneumonia, traumatic fracture of Ribs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, [illegible] the following:
(a) Date of injury September 28th 1945 at M.
(b) Where did injury occur? Art Museum 12-2 Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Grafton M.D. Medical Examiner.
Date signed Oct. 18 1945

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any item of information should be carefully supplied.

G33392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

G33392 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Mc=Cabe Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Mc=Cabe Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis F. Hogan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0829

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Elizabeth V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5-1880

8. AGE: Years 65 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Black & Decker

FATHER
12. Name John W. Hogan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Mc=Gee
15. Birthplace Ireland

16 (a) Informant Margaret M. Abidot
(b) Address 615 Mc=Cabe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John C. Moran
(b) Address 3000 E Baltimore St

19 (a) Oct 19 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945 at 11:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/45 to 10/18/45 and that I last saw h IM alive on 10/18/45

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	6 hrs.
Due to (b) Hypertensive Cardio	
Due to (c) Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify) (Specify place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3274 York Rd Date signed 10/19/45

VS 150

G33393 BALTIMORE CITY HEALTH DEPARTMENT ✓ G33393

CERTIFICATE OF DEATH 95c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Roland Ave.
(c) Hospital or institution: Fairleigh Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 514 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A. Weddingfield

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Henry.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1863

8. AGE: Years	Months	Days	If less than one day
81	10	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Adam M. Neus
13. Birthplace Bavaria

MOTHER
14. Maiden Name Barbara Huber
15. Birthplace Bavaria

16 (a) Informant Mrs. M. Keck
(b) Address 4204 Powell Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John. J. Mahan
(b) Address 3000 E. Balto. St.

19 (a) Date received by registrar OCT 19 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945 at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 1945 to Oct 17 1945, and that I last saw h[illegible] alive on Oct 17 1945.

Immediate cause of death	Duration
myocardial insufficiency	1 day.
Due to cerebritis.	?
Due to	
Other Conditions hypertension arteriosclerosis.	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L C Robinet M.D.
Address 447 N. Kenwood Ave. Date signed 10/17/45

VS 150

633394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

✓ 633394 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) (5)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Grove Rd (If rural give location)
(e) Citizen of foreign country? Germany (Yes or No) If yes, name country

3 (a) FULL NAME Vernon L Neighoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1928

8. AGE: Years	Months	Days	If less than one day
17	11	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business

FATHER
12. Name Thomas Neighoff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Schaufele
15. Birthplace Baltimore Md.

16 (a) Informant Thomas Neighoff
(b) Address 601 Grove Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John H. Galenton
(b) Address 2326 Aiken St.

19 1945 (Date rec'd by registrar) Washington Nottingham, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945, at 7:50 PM

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/1 S.M.F. PM
(a) Date of injury October 17, 1945 7:15 P.M.
(b) Where did injury occur? Grove Rd & Frederick
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Car into embankment

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 10-18-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G33395
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution:
So. Balto. Genl. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 E. Fort Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Les Fagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-83

8. AGE: Years	Months	Days	If less than one day
63	11	27	hr. min.

9. Birthplace Maryland
(town, county, and state)

10. Usual Occupation

11. Industry or business Unemployed.

FATHER
12. Name John Fagan
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bernadette Fagan
(b) Address 1632 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1426 Light St.

19 (a) (Date received by registrar) (b) Registrar

19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1945 to Oct 17, 1945 and that I last saw him alive on Oct 17, 1945

Immediate cause of death	Duration
Ruptured aortic aneurysm	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ruptured aortic aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. E. Fulick
Address 1213 Light St. Date signed 10/18/45

VS 150

X

G33396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33396 Registered No. 49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days.
(e) Length of stay in Baltimore (yrs., mos., or days) same.

2. USUAL RESIDENCE OF DECEASED:
(a) State West Va. (b) County Kanawha
(c) City or town Shinnston (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Alene McClung

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White.	Married.

6 (b) Name of husband or wife Lt. (s.g.) Edward H. McClung
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1908

8. AGE: Years	Months	Days	If less than one day
37	1	23	hr. min.

9. Birthplace Sandis ~~Charleston~~, West Va. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business " "

FATHER
12. Name Orie L. Meek
13. Birthplace Doddridge Co., West Va.

MOTHER
14. Maiden Name Emgie Rittenhouse
15. Birthplace Harrison Co., West Va.

16 (a) Informant Husband & Father
(b) Address See above

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/19/45 (month) (day) (year)
(c) Cemetery or crematory Masonic Cem.
Location Shinnston, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 19 1945 (b) (Local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1945, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1945 to Oct. 19 1945, and that I last saw her alive on Oct 19 1945.

	Duration
Immediate cause of death Intestinal obstruction	2 mos.
Due to Generalized carcinomatosis	2 mos. +
Due to Carcinoma of ovary.	10 mos. +
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug. 25, 1945
Major findings of operation: Generalized carcinomatosis.
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald F. Rays, M. D.
Address Hosp. for Women of Md. Date signed 10/19/45

X

G33397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G33397 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 East Biddle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 East Biddle (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM F. BARBINE

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-5611

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Laura Barbine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1867

8. AGE: Years 78 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William E. Barbine
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Eleanora Maguira
15. Birthplace Balto., Md.

16 (a) Informant Mr. William K. Tolley
(b) Address 3605 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Wm. J. Tickner, M.D.

19 (a) OCT 19 1945 (Date received by registrar) (b) Wm. J. Tickner, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/45 19 , at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 10/19/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Be sure all items of information should be carefully supplied. The

633398

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a 633398 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 38 2nd and Albemarle
(c) Hospital or institution: The Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Harrison Blvd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MRS Elizabeth Carney Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward P. Murray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1860

8. AGE: Years	Months	Days	If less than one day
84	10	8	hr. min.

9. Birthplace Maryland (Timonium) (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Uriah Parks Carney
13. Birthplace Maryland

MOTHER
14. Maiden Name Angeline Rawlings
15. Birthplace Virginia

16 (a) Informant Mrs. Elizabeth Armstrong
(b) Address 2411 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
(b) Address No. & Pa. Aves. Balto., Md.

19 (a) 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1945, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945 to Oct 19 1945, and that I last saw h[illegible] alive on Oct 19 1945

Immediate cause of death	Duration
Myocardial infarction.	
Due to [redacted] coronary arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul S. Crane M. D.
Address U. M. Hospital Path. Date signed 10-19-45

VS 150

G33399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G33399

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkins & Caton Aves

(c) Hospital or institution: St. Agnes Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 342 So. Louden Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ambrose Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1877

8. AGE: Years 68 Months 4 Days 12 If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Operator

11. Industry or business

FATHER 12. Name Michael Kaiser

13. Birthplace Md

MOTHER 14. Maiden Name Mary A Yath

15. Birthplace Md

16 (a) Informant Wife Mildred

(b) Address 342 So Louden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director George A Fuller

(b) Address Fullers 9 Fayette St

19 (a) (Signature of person acting by registrar) Washington Williams M.D. Registrar

10 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/45 19 at 9:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1945 to 10/17 1945.

and that I last saw h.i.m alive on 10/17 1945.

Immediate cause of death (a) Coronary Thrombosis

Due to (b) Arterio sclerosis

Due to (c)

Other Conditions Renal Insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Clifford Rauch Jr. M.D.

Address St. Agnes Hosp Date signed 10/20/45

X

G33400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

G33400 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 16 mos

2. USUAL RESIDENCE OF DECEASED: Baltimore Co.
(a) State Md (b) County Catonsville
(c) City or town Baltimore Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 - Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anita Kowalczyk

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1944

8. AGE: Years	Months	Days	If less than one day: hr.	min.
1	4	8		

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward J Kowalczyk
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Anita Browne
15. Birthplace Baltimore

16 (a) Informant Mary J Kowalczyk
(b) Address 1822 Frederick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Park
Location Washington Blvd.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

19 (a) (Date rec'd by registrar) Hilda Washington Williams Registrar

OCT 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1945, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1945 to 10/18 1945, and that I last saw her alive on 10/18 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Acute tracheo bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry F. Rolfes, M.D.
Address Mercy Hospital Date signed 10/18/45

633401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 633401

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 A E. University Pky
(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give location)
(d) Street No. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Harwood Massey Zeisel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Raymond Zeisel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1872

8. AGE: Years	Months	Days	If less than one day
73	y 2	3	hr. min.

9. Birthplace Queen Ann's County
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Josiah Massey
13. Birthplace Kent County

MOTHER
14. Maiden Name Anne Evans
15. Birthplace Queen Ann's

16 (a) Informant Theodore Bauer
(b) Address 300A E. University Pky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22 1945 (month) (day) (year)
(c) Cemetery or crematory Chester Cem.
Location Chestertown Md.

18 (a) Funeral director Marvin Williams
(b) Address Chestertown Maryland

OCT 20 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1945, at 4 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1945 to 10/19 1945, and that I last saw h[illegible] alive on 10/17 1945.

Immediate cause of death Carcinoma of ovary(?) with metastases to lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sheldon Eastland, M.D.
Address Md. State Dept. of Health Date signed 10/19/45

VS 150

G33402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 659 West Fayette
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 659 West Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORLANDO FRANKLIN TAYLOR

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1885

8. AGE: Years 60 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Salisbury Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Norma Taylor
(b) Address 1015 W. Rowland St

17 (a) Burial (b) Date thereof 10/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) OCT 20 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/45 19 5:15 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner
Date signed 10/19/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution:
Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Luft

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife Annie Patterson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	9 10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Insurance agent
11. Industry or business

FATHER 12. Name Henry W. Luft
13. Birthplace Germany

MOTHER 14. Maiden Name Kate Roache
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudenwood
Location Parkville Md

18 (a) Funeral director William Cahn Jr
(b) Address 1217 E Fort Ave

19 OCT 20 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945 at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 18 1945, and that I last saw him alive on Oct 16 1945.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Acute Bronchitis	2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C Gill Hall M. D.
Address 1631 E North Ave Date signed 10/19/45

VS 150

G33104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G33104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: Saint Joseph Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days

(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Balto

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 527 Richwood Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME MINNIE P. MAYO

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-88

8. AGE: Years 57 | Months 9 | Days 17 | If less than one day hr. min. 58

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Slavin

13. Birthplace Md

MOTHER

14. Maiden Name

15. Birthplace Md

16 (a) Informant Joseph C. Mayo

(b) Address 527 Richwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Md

18 (a) Funeral director Milburn Co Inc

(b) Address 1214 Park Ave

19 (a) Date received by Registrar OCT 20 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1945, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30, 1945 to 10-19, 1945, and that I last saw her alive on Oct. 19, 1945.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Uremia

Due to Chronic nephritis

Other Conditions Diabetes mellitus. Gangrene - left foot. Anasarca.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Anasarca. Chronic nephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Everard

Address 1214 Park Ave Date signed 10/19/45 M. D.

VS 150

G33405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. G33405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address List & Hampnett Ave.

(c) Hospital or institution:

Pine Ridge Nursing Home 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 402 E. 25th St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ELIZABETH MITCHELL

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William F. Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1864

8. AGE: Years 81 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER

12. Name Timothy Callahan

13. Birthplace U. S. A.

MOTHER

14. Maiden Name Mary Barton

15. Birthplace Balto., Md.

16 (a) Informant Mrs. Georgia Gascoigne

(b) Address 6425 - 33d St., N.W., Wash., D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

OCT 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1945 at 4 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Oct 17, 1945 and that I last saw h. alive on Oct 10 1945.

Immediate cause of death

Duration

Due to Myocarditis

Due to Arteriosclerosis

Other Conditions Senile Dementia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature James W. Katzenberger, M.D.

Address 721 Medical Arts Bldg. Date signed 10/19/45

James W. Katzenberger

VS 180

633:06

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

633:06 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home 15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Windsor Court Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES CARMEC NICHOLSON, D.D.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Blanche B. Nicholson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1858

8. AGE: Years	Months	Days	If less than one day
87	2	19	hr. min.

9. Birthplace Piedmont, W. Va. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Michael Nicholson
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Betson
15. Birthplace W. Va.

16 (a) Informant Mr. Charles B. Nicholson
(b) Address 109 Butler Rd., Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1945 at 855 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 29 1943 to Oct 17 1945 and that I last saw h alive on Oct 17 1945.

Immediate cause of death — Duration

(a) Chronic Myocarditis 4 yrs

Due to

Due to

Other Conditions (a) Arteriosclerosis 4 yrs
(b) Chronic Myocarditis 4 yrs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Richardson M.D.
Address 117 W. 25 St. Date signed Oct 19 1945

VS 150

633:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

633:07

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 330 Suffolk Rd.

(c) Hospital or institution: 12

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 330 Suffolk Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ALICE GERTRUDE WILKINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Allen Byron Wilkinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	3	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name - Underwood

13. Birthplace -

MOTHER

14. Maiden Name -

15. Birthplace -

16 (a) Informant Mrs. Florence Taylor

(b) Address 330 Suffolk Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 20 1945 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Oct. 18, 1945 at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1945. to Oct. 18, 1945. and that I last saw her alive on Oct. 18, 1945.

Immediate cause of death	Duration
Acute dilatation of heart	12 hrs.
Due to Aortic regurgitation & Mitral stenosis.	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible] Jr. M.D.

Address 1613 E. North Ave Date signed 10-19-45

VS 190

X

Spec.—9-39—A. & Co.—250 Blks.

G33:08 G33:08

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. ✓107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2043 E Lombard St St. Ward)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mitchell Clayton Clark

(a) RESIDENCE NO. 2043 E Lombard St St. 2-1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 18 Mar 45

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond Gordon Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Margaret Emma Zylack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md.

14 Informant Mother
(Address) 2043 E Lombard St.

15 Filed OCT 20 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 45 ✓

17

I HEREBY CERTIFY, That I attended deceased from 19 Oct. 1945 to 19 Oct. 1945

that I last saw h[illegible] alive on 19 Oct. 1945

and that death occurred, on the date stated above, at 12 55 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hilda [illegible] M. D.

Oct. 1945 (Address) 2214 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer ✓

DATE OF BURIAL 10/20 1945

20 UNDERTAKER McGann W. E. Dyer's & Sons

ADDRESS Lombard & Ann St

IMPORTANT—See instructions on back of certificates.

633:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 633:09

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 VALLEY STREET.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 VALLEY STREET. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELLEN BAKER.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1868

8. AGE: Years	Months	Days	If less than one day
77	6	6	hr. min

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Baker
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Hobard
15. Birthplace Ireland

16 (a) Informant Mrs. George Stedman
(b) Address 1019 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cemetery
Location 1300 Moreland Ave

18 (a) Funeral director Elmer H. Copeland & Son
(b) Address 924 C. Cager St.

OCT 20 1945 (Date rec'd by registrar) (c) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 19 1945 at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 19 1945, to OCT 19 1945 and that I last saw her alive on OCT 18 1945.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS SEPT 19	1945
Due to ARTERIOR SCLEROSIS	1945
Due to	
Other Conditions SENILITY.	1945

(Include pregnancy within three months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Chantier
Address 3013 ST PAUL STREET Date signed OCTOBER 19TH 1945

G33410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G33410

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry + Caton Aves.
(c) Hospital or institution: St Agnes Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Mary's Ind. School Mulberry + Caton Aves
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry Jacobs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-29

8. AGE: Years	Months	Days	If less than one day hr.	min.
15	11	9		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Md.

MOTHER
14. Maiden Name Edna Kirby
15. Birthplace Md.

16 (a) Informant Edna Jacobs
(b) Address 6 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Doepel's Sons
(b) Address Lombard + Ann Sts.

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

OCT 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1945, at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1945, to 10-18 1945, and that I last saw him alive on 10-18 1945.

Immediate cause of death	Duration
Cardio-respiratory failure - Bil Pneumonia	Edema
Due to Cerebral anoxemia (convulsions)	
Due to Appendectomy + Abd. Lap + acute suppurative appendicitis +	
Other Conditions poss. reported vicious following G.O.E. anesthesia (Include pregnancy within 3 months of death)	

Date of operation 10-18-45
Major findings of operation: Acute suppurative appendicitis - poss. reported vicious
Results of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N.I.M.
(a) Accident, suicide, or homicide Accident - contributed
(b) Date of occurrence 10-17- 25/2 P. M
(c) Where did injury occur? St. Mary's Industrial School (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? Playing
(e) Means of injury Injury while playing football

23. Signature Robert B McFadden M. D.
Address St Agnes Hosp. Date signed 10-18-45

Howard J. Masden, M. D. X

VS 150

633:11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

633:11 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital 8 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Rutland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles N. McCall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/12/80

8. AGE: Years 65 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Alice Halliday
(b) Address 1506 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Wendell E. Humphreys
(b) Address 6067 Harford Rd

19 (a) (Date received) OCT 20 1945 (b) Huntington-Williams, Mortician

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/4 1945 to 10/17 1945 and that I last saw h[illegible] alive on 10/17 1945

Immediate cause of death
Cardio respiratory failure
Due to Malnutrition & cachexia
Due to Generalized arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Lloyd Jr. M. D.
Address St. Joseph's Hosp
Date signed 10-17-45

G33112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52 B Registered No. G33112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address, if in hospital or institution: Greenspring & Belvedere Aves.
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1623 Ruxton Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leah Rudolph

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Late Abram
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business: None

FATHER
12. Name: Samuel Rudolph
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rachael ?
15. Birthplace: Ruusia

16 (a) Informant: Richard B. Rudolph
(b) Address: 3332 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 21, 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date received by Registrar) (b) Registrar: Huntington Williams M.D.
OCT 20 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1945 at 9P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1944 to 10-18 1945, and that I last saw h alive on 10-18 1945.

Immediate cause of death: Carcinoma of bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H Edmund Kurn M.D.
Address: Levindale Date signed 10/18/45

633113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 929

633113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 N. Eden
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N. Eden St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Davis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Liston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1885

8. AGE: Years 60 | Months 6 | Days 28 | If less than one day hr. min 29

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Carter
13. Birthplace Va

MOTHER
14. Maiden Name Polly West
15. Birthplace Va

16 (a) Informant Kate Johnson
(b) Address 1118 Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kelson
(b) Address 1303 Presstman St

19 (a) (b) Huntington Williamson Md

OCT 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18th 1945 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1 1945 to October 18 1945, and that I last saw h[illegible] alive on Oct 18th 1945

Immediate cause of death Bronchopneumonia — Duration 5 days

Due to

Due to

Other Conditions Chronic Valvular Heart Disease

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Thomas
Address 107 N. Main St Dunkirk N.Y.
Date signed 10/19/45

G33414

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G33414
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed~~, or divorced.
F	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day hr.	min.
58				

9. Birthplace (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Michael McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Mrs Kathleen Bonhagle
(b) Address 1924 N. Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22nd 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Leo G. Leo Cook
(b) Address 1701-03 N. Patterson Park Ave

19 OCT 20 1945 (Date rec'd by registrar) Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1945, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13 1945, to 10-19 1945, and that I last saw her alive on 10-19 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Cardiac Failure	
Due to Hypertension, arteriosclerosis	
Other Conditions Broncho-Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 10-19-45

VS 180

97

G33415

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G33415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 & 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca J. Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 6 - 1876

8. AGE: Years 69 | Months 3 | Days 13 | If less than one day: hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, or state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William Bosley
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Rebecca Bosley
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Geo. Hicks Baptist Pastor
(b) Address Marley Neck Rd - R.D. 26 Balto Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23 - 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Zion Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Frank Cook & Son
(b) Address 1600 W. North Ave

19. (a) (Date rec'd by registrar) OCT 20 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 - 1945 at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1945 to Oct 19 1945, and that I last saw h[er] alive on Oct 19 1945.

Immediate cause of death	Duration
Acute Myocardial Failure	1 week
Due to Chronic Myocarditis & Auricular Fibrillation	Unknown
Due to Acute Tracheobronchial Laryngitis	1 week
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cohen M.D.
Address 1914 N. North Ave Date signed 10/20/45 M.D.

VS 150

G33416 BALTIMORE CITY HEALTH DEPARTMENT G33416
Registered No.

CERTIFICATE OF DEATH 74a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES G. ROSENTHAL
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 11 1929
8. AGE: Years 16 | Months 3 | Days 7 | If less than one day: hr. min.
9. Birthplace Bath, Md.
(Town, county, and state)
10. Usual Occupation Student - City
11. Industry or business College

FATHER
12. Name Sidney W. Rosenthal
13. Birthplace Bath, Md.

MOTHER
14. Maiden Robertine Lyon,
15. Birthplace Georgia.

16 (a) Informant Mrs. S. W. Rosenthal
(b) Address 2311 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/45 (month) (day) (year)
(c) Cemetery or crematory Chas Sharon
Location Bath, Md.

18 (a) Funeral director Burial Londheim & Son
(b) Address 1902 Eutaw Place

19 (a) (Date received by Local Registrar) OCT 20 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/45 19 . at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945 to 10/18 1945 and that I last saw him alive on 10/18 1945.

Immediate cause of death Respiratory obstruction & asphyxiation, pericarditis
Due to Acute monocytic leukemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy Acute pericarditis, pleural effusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury HAMMER

23. Signature Daniel Hamburger M.D.
Address Sinai Hospital Date signed 10/18/45

VS 150

633-17 — 82B — 633-17

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Frederick Rd.
(c) Hospital or institution: Ventnor Lodge. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME ISAAC HUTZLER.

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-26-8279.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of ~~husband or~~ wife Myra R. Hutzler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1867.

8. AGE: Years	Months	Days	If less than one day
78	9	11	hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)
10. Usual Occupation Prop. Wholesale Jewelry
11. Industry or business Business.

FATHER
12. Name David Hutzler,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sarah Brown,
15. Birthplace Norfolk, Va.

16 (a) Informant Mr. Harry Myers,
(b) Address 2015 Greenberry Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10.22.45. (month) (day) (year)
(c) ~~Cemetery or~~ crematory Loudon Park.
Location Balto. Md.

18 (a) Funeral director Harid Sonneborn & Sons
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) OCT 20 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th. 1945 at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1938 to Oct. 19 1945, and that I last saw h[er] alive on Oct 15 1945.

Immediate cause of death: Cerebral embolism

Due to: arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Horace J. Cahen M. D.
Address Marlborough Apts. Date signed 10/19/45

Huntington Williams, M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 633418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4024 Garrison Blvd.
(c) Hospital or institution:

15-19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany.

3 (a) FULL NAME GUSTAV HIRSCHMANN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minna Hirschmann.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1882.

8. AGE: Years	Months	Days	If less than one day
63	1	15	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired Mnfgr.
11. Industry or business

FATHER
12. Name Moritz Hirschmann,
13. Birthplace Germany.

MOTHER
14. Maiden Name Johanna Katz,
15. Birthplace Germany.

16 (a) Informant Mr. Hans Veith,
(b) Address 4507 Prospect Circle.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/22/45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) OCT 24 1945 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19th. 1945, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945, to Oct 19 1945.
and that I last saw h[illegible] alive on Oct 18 1945

Immediate cause of death Coronary occlusion — Duration

Due to Hypertension Cardio-Vascular disease

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature KUTTNER, M.D.
2301 Eutaw Place
Address 2301 Eutaw Place, Baltimore, Md. Date signed 10/29/45 M. D.

Huntington Williams, M.D.

X

63319

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937 Registered No. 63319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 523 South Greene
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 South Greene (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Boyer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Mamie Boyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 24, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Boyer Sr.
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Mary Mathias
15. Birthplace Balto., Maryland

16 (a) Informant Charles Boyer
(b) Address 1108 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24. 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore city

18 (a) Funeral director Joseph A. Kirby
(b) Address 4000 Mount street

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/45 19 , at 1.00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D.
Medical Examiner.
Date signed 10/19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33420 Dudderar 83a G33420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4017 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Mt Airy
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John William Dudderar
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 - 1868

8. AGE: Years	Months	Days	If less than one day
77	2	27	hr. min.

9. Birthplace Carroll County, Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Dennis W. Dudderar
13. Birthplace Maryland

MOTHER 14. Maiden Name Annie Colletown
15. Birthplace Maryland

16 (a) Informant Bradley T. Baker
(b) Address 4017 Edmondson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22-45 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Cem.
Location Winfield, Md.
18 (a) Funeral director H. L. Hartzler & Sons
(b) Address Union Bridge & New Windsor, Md.
19 OCT 20 1945 Huntington for Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Oct 20 1945, and that I last saw h— alive on Oct-20 19 45

Immediate cause of death	Duration
Myocardial Asthma	3 da.
Due to Hypertension Essential	5 yrs.
Due to Cerebral Hemorrhage	7 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Koons M. D.
Address 1202 St Paul St Date signed Oct 20/45

VS 3

G33:21

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G33:21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Frances Hunt

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hamilton H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1876

8. AGE: Years 69 | Months 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilson T Beckner
13. Birthplace Va

MOTHER
14. Maiden Name Mary McCormack
15. Birthplace Va

16 (a) Informant Mrs R Hall
(b) Address 2226 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)
(c) Cemetery or crematory Antioch
Location Unknown Va

18 (a) Funeral director Wilson Corp Inc
Address 1357 Lanvale St

19 (a) OCT 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945, at 9 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1945 to 10/18 1945 and that I last saw her alive on 10/17 1945.

Immediate cause of death	Duration
(a) Myocardial Cardio Vascular Disease	5 yrs.
Due to (b) with Cardiac Decompensation	
Due to (c)	
Other Conditions Carcinoma Urinary Bladder (Include pregnancy within 3 months of death)	3 mos?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Karl Thomas M.D.
Address 212 N Patterson Pk Ave Date signed 10/20/45

VS 150

G33422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G33422 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 McAlear Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 McAlear Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alfred R Browning

3 (b) If veteran, name war No | 3 (c) Social Security Account No. 218-18-9858

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife /
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1889

8. AGE: Years 55 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Wilbur T Browning
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma A Corbo
15. Birthplace Baltimore Md

16 (a) Informant Wilbur T Browning
(b) Address 1111 McAlear Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilbur T Corbo
(b) Address 1202 E Lombard St

19 (a) OCT 20 1945 (Date rec'd by registrar) (b) Huntington Wilson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1945 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 19 1945 and that I last saw him alive on Oct 19 1945

Immediate cause of death Pulmonary T B — Duration 1 mo

Due to Laryngeal T B

Due to Tuberculosis

Other Conditions Pain of Hypopharynx

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 600 N Bulton St Date signed Oct 19 1945

VS 150

133-123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 133-123 / 1225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redmond & Greene Sts

(c) Hospital or institution: University of Md. Hosp. 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 301 N. Fulton Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Elizabeth Bobbitt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wh.	John A. Bobbitt (Postmaster Corps U.S.)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (May) 18, 1914

8. AGE: Years	Months	Days	If less than one day
31	8		hr. min.

9. Birthplace Roanoke, Va. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business at home

FATHER 12. Name	Richard F. Mabry
FATHER 13. Birthplace	Roanoke Va
MOTHER 14. Maiden Name	Louise Nicely (Anderson)
MOTHER 15. Birthplace	Roanoke Va

16 (a) Informant Mr. Geo R. Barrett

(b) Address 301 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)

(c) Cemetery or crematory Fairview Cem.

Location Roanoke, Va

18 (a) Funeral director John J. Conway & Son

(b) Address 101 03 Gilmor St

19 10/20/45 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20th 1945, abt. 5.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945 to 10/20 1945, and that I last saw her alive on 10/20 1945.

Immediate cause of death Peritonitis

Intestinal obstruction — Duration

Due to Adhesions about pelvic organs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: Intest. obstr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Roy H. Corbin, Jr. M.D.

Address Union Hosp Date signed 10/20/45

VS 150

633424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

633424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Azzie Lee Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race Color. | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 42 | Months — | Days 10 | If less than one day hr. min.

9. Birthplace Arkansas (Town, county and state)
10. Usual Occupation Beautician
11. Industry or business

FATHER 12. Name Bill Thompson
13. Birthplace Louisiana

MOTHER 14. Maiden Name Mary E. Watts
15. Birthplace Louisiana

16 (a) Informant Anna Belle Woods
(b) Address 1222 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Ellenay, Oklahoma

18 (a) Funeral director Mrs Lena A. Hulland
(b) Address 1631 Druid Hill Ave.

19 (a) (Signature of Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945 to Oct 18 1945, and that I last saw her alive on Oct 18 1945.

Immediate cause of death	Duration
Uraemia	
Due to Carcinoma of Cervix	
2 Metastasis to Bladder	
Due to Causing Hydronephrosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Hydronephrosis
Hydroureter
of autopsy Metastasis to bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Williams M. D.
Address Date signed 10/17/45

X

G33:25 ✓ G33:25

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County New Jersey
(c) City or town [illegible] Newark
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo B Weingal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Merchant
11. Industry or business

FATHER
12. Name: Solomon
13. Birthplace: Poland

MOTHER
14. Maiden Name: Leah
15. Birthplace: Poland

16 (a) Informant: Hospt Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-20-45 (month) (day) (year)
(c) Cemetery or crematory: New York City
Location: Jack Lewis Inc

18 (a) Funeral director: 1439 E. Balto St.
(b) Address: Huntington Williams, Md

19 (a) [illegible] 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12:48 AM 10/20/45 1945, at 2:48 M.

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 10/3 1945, to 10/20 1945, and that I last saw h alive on 10/19 1945.

Immediate cause of death	Renal Failure	
Due to	Transfusion Reaction	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Transfusion
Renal Mech
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. F. Goldenberg M. D.
Address Sinai Hosp. Date signed 10/20/45

VS 150

X

633-126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 633-126 Registered No. 920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 E 25th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 E. 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE E. CARR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife DAVID.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8-1856

8. AGE: Years	Months	Days	If less than one day
89	3	12	hr. min.

9. Birthplace Greencastle Pa (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Garner.
13. Birthplace Pa.

MOTHER
14. Maiden Name Henrietta Barnhart
15. Birthplace Pa.

16 (a) Informant Geo. W. Carr
(b) Address 1514 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Lodge Hill
Location Chambersburg Pa.

18 (a) Funeral director Clement & Hoffman
(b) Address 1639 E. Broadway

19 (a) Filed 1945 (b) Huntington Mills Registrar
(Date received by Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1945 to Oct. 20 1945, and that I last saw her alive on Oct 20 1945.

Immediate cause of death, Cystic Intestinal Ileus

Duration 14 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. Peters M. D.
Address 817 Hamilton Ter. Date signed Oct 24 1945

633127 94a 633127

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 McELDERRY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 McELDERRY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES E. ZEITERS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: LILLIAN ZEITERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 24 1911

8. AGE: Years	Months	Days	If less than one day
33	10	26	hr. min.

9. Birthplace BALTIMORE CO. MD. (Town, county, and state)
10. Usual Occupation SPARROWS POINT STEEL CO.
11. Industry or business

FATHER
12. Name WILLIAM ZEITERS
13. Birthplace PA.

MOTHER
14. Maiden Name MARY CALLENDER
15. Birthplace BALTO. MD.

16 (a) Informant BLANCHE KARMANN (SISTER)
(b) Address 2901 McELDERRY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 22/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Sally & Gerlach
(b) Address 403 S. WOLFE ST.

(c) Date received by registrar OCT 21 1945 (d) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH OCT. 20 19 45 at 4/45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 19 45 to Oct 20 19 45, and that I last saw him alive on Oct 20 19 45.

Immediate cause of death: Coronary Thrombosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Klumes M. D.
Address 2623 E. Monument Date signed 10/20/45

Benedict Stolarski M.D.

G33428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G33428 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Kalinowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-8147

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Joseph Kalinowski (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Poland (Town, county and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Lawrence Rykaczewski
13. Birthplace Poland

MOTHER
14. Maiden Name Amelia Andrzychowski
15. Birthplace Poland

16 (a) Informant Anthony Rykaczewski
(b) Address 516 S. Bond Street Brantley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 22 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address [illegible] S. Chester Street

19 (a) OCT 21 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1945 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1945 to Oct 19 1945 and that I last saw h[illegible] alive on Oct 19 1945

Immediate cause of death	Duration
Hypostatic Pneumonia	10 Days
Due to Carcinoma of Stomach	4 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rymarek M. D.
Address 801 S. Kenwood Ave Date signed Oct 20 45

VS 150

Huntington Williams, M.D.

G33429 — BALTIMORE CITY HEALTH DEPARTMENT — G33429 Registered No.

CERTIFICATE OF DEATH

A4a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N Chester Street
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Chester
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ~~Frederick~~ WIENER (Ida) NEE IDA NEWMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Jewish	Married

6 (b) Name of husband or wife Theodore Wiener
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1890

8. AGE: Years	Months	Days	If less than one day
55	2		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Newman
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta ?
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Highway & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

1945 OCT 21 (Date rec'd by registrar) (b) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945 at 11 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1945 to Oct 18 1945 and that I last saw her alive on Oct 18 1945

Duration

Immediate cause of death Acute cardiac failure
Due to Irreversible Myocardial infarction
Due to Coronary arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Sandt M.D.
Address Union Memorial Hosp signed 10/19/45

X

G33430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33430
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3917 Belle Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Beelto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Belle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME IDA PASSMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Aaron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-45 (month) (day) (year)
(c) Cemetery or crematory Brai Israel
Location Southern Ave
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E Belt St

19 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1945, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to October 21 1945, and that I last saw h alive on October 21 1945.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 7 years 4 days
Due to: Congestive Heart Failure
Due to:
Other Conditions: Diabetes Mellitus — 7 years
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leo Aaronman
Address 1201 Pyler Mews St Date signed 10-21-45 M. D.

VS 150

92D

633431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

633431 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 138 N. Bdwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX BECKER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Poland

MOTHER 14. Maiden Name Not Known
15. Birthplace Poland

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1945, at 12:55 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1945, to 10/21 1945; and that I last saw him alive on 10/20 1945.

Immediate cause of death Cardiac failure
Due to Peripheral circulatory collapse
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation 10/12/45
Major findings of operation: Refused Lowell.
of autopsy:

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. F. Goldenberg M.D.
Address Sinai Hosp. Date signed 10/24/45

VS 150

G33432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33432 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1920 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Female	White	Married

6 (b) Name of husband or wife Meyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
54				

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Herman
13. Birthplace Russia

MOTHER
14. Maiden Name Tobia
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-45 (month) (day) (year)
(c) Cemetery or crematory North Pt Rd.
Location North Pt. Road

18 (a) Funeral director Jack Lewis Jr
(b) Address 1439 E. Balto St.

19 (a) 21 194 (Date rec'd by registrar) (b) Registrar

Theodore Thompson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1945, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1942 to Oct 21 1945, and that I last saw her alive on 10/21 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore Compton M. D.
Address 2201 Eutaw Place Baltimore - Md. Date signed 10/24/45

VS 150

94a

633433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

633433 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1640 N. Bond street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1640 N. Bond street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM S. COUZENS

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ellen Nora Couzens
6 (c) If alive, give age: 186 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, ~~1854~~

8. AGE: Years ~~95~~ 84 | Months 1 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Retired- Lieut. Balto.
11. Industry or business: City Fire Dept.

FATHER
12. Name: Stephen Couzens
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Murphy
15. Birthplace: Ireland

16 (a) Informant: Mrs. James L. Hubbard
(b) Address: 1640 N. Bond street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/22/45 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial Park
Location:

18 (a) Funeral director: Chas. J. Evans & Son
(b) Address: 118 W. Mt. Royal Ave

19 (a) Date received by Local Registrar: OCT 22 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 19 1945 at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1945 to Oct. 19, 1945; and that I last saw him alive on Oct. 19 1945.

Immediate cause of death	Duration
Chronic nephritis	Years?
Due to	
Due to	
Other Conditions Uraemia	2 days

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ~
(b) Date of occurrence: ~ at ~ M
(c) Where did injury occur? ~ ~ ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place) ~
(e) Means of injury:
23. Signature: Frank H. Ogden M. D.
Address: 2701 N. Calvert St Date signed: 10-19-45

(OVER) X

G33134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G33134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 Thornbury road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Thornbury road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSALIE STIRLING GRAHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
----	------	Female	White	Widow

6 (b) Name of husband or ~~wife~~ Joseph Graham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1867

8. AGE: Years	Months	Days	If less than one day
77	10	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name W. Murray Stirling
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rosalie Keys
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Elsie Stirling
(b) Address 1815 Thornbury road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave

19 (a) [illegible] (b) [illegible]
(Date received by local registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 19 1945, and that I last saw h[illegible] alive on Oct 18 1945.

Immediate cause of death	Duration
(a) Senility	Unknown
Due to	
Due to	
Other Conditions Pernicious Anemia	Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. R. Greenstrong Jr. M. D.
Address 7423 St. Paul St Date signed 10/20/45

162B

G33435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 68

Registered No. G33435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C (b) County
(c) City or town Sumter (If outside city or town limits, write RURAL, and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Everett Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26 - 1904

8. AGE: Years	Months	Days	If less than one day
41	5	24	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation SEAMAN

11. Industry or business

FATHER
12. Name Lee A. Baker
13. Birthplace South Carolina

MOTHER
14. Maiden Name Gardner
15. Birthplace Ireland

16 (a) Informant Hospital records
(b) Address University Hosp

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)
(c) Cemetery or crematory
Location Sumter S.C.

18 (a) Funeral director Ulmer Funeral Home
(b) Address 200 E Calhoun St

19 OCT 22 1945 (Date) Huntington Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1945, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945, to Oct 20 1945, and that I last saw h[illegible] alive on Oct 20 1945.

Immediate cause of death Pulmonary Edema — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. M. Lindsay Jr M.D. M. D.
Address University Hosp Date signed 10-20-45

VS 150

Over

633436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46D

Registered No. 633436

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or institution St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Lowe
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/68

8. AGE: Years	Months	Days	If less than one day
77	7	16	hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name Raphe Lowe
13. Birthplace Md

MOTHER
14. Maiden Name Rue Brown
15. Birthplace York Co Pa

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-1946 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Parkton Md

18 (a) Funeral director H. Hamm Kelly
(b) Address Parkton Md

19 (a) OCT 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-46 19 at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/46 19 to 10/21/46 19 and that I last saw him alive on 10/21/46

Immediate cause of death — Duration
Terminal Pneumonia
Due to Intestinal obstruction
Due to Epithelial Carcinoma of recto-sigmoid
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address St. Joseph's Hosp. Date signed 10-21-46

VS 190

G33437 HEP

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30B

G33437 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15- 5 - 19
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Albemarle St. (If rural give location)
(e) Citizen of foreign country? ?? (Yes or No) If yes, name country

3 (a) FULL NAME Dominick Carnalie

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sophia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1884

8. AGE: Years	Months	Days	If less than one day
61	?	?	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Constantine
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia
15. Birthplace Poland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date received by Registrar) OCT 22 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1945 at 6:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 26, 1930 to Oct. 15, 1945 and that I last saw him alive on Oct. 15, 1945.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions Tabo-paresis, Generalized arteriosclerosis — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Davis M. D.
Address 4940 Eastern Ave Date signed 10-19-45

VS 150

3021

633138

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

633138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3515 Hilton Rd.
(c) Hospital or institution Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ellen Amanda Jones
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1870

8. AGE: Years	Months	Days	If less than one day
74	9	22	hr. min.

9. Birthplace Constantine Pa (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business Nursing

FATHER
12. Name Robert E. Jones
13. Birthplace York Co Pa

MOTHER
14. Maiden Name Lilly Jones
15. Birthplace York Co Pa

16 (a) Informant Cassandra Jones
(b) Address Forest Hills.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/1945 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cemetery
Location Forest Lawn Rd

18 (a) Funeral director H. Norval Tebbs
(b) Address Forest Lawn

19 (a) OCT 22 1945 (Registrar)
Huntingtown Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20th 1945 at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Not attended 19
and that I last saw h alive on 19

Immediate cause of death Heart - Failure — Duration unknown

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Karl Trump M. D.
Address Lombard & Hyatt Date signed 10-24-45

VS 150

G33439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1

Registered No. G33439

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIE A. SUMMERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Ernest Summers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1898

8. AGE: Years	Months	Days	If less than one day
47	9		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Hunter
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Va.

16 (a) Informant Mr. Ernest Summers
(b) Address 1021 Madison Ave.

17 (a) Burial (b) Date thereof 10-22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 22 1945

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 19, 1945, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1.6 1945 to 10.19 1945
and that I last saw h[illegible] alive on 10.18 1945

Immediate cause of death: Hypertensive cardio-renal disease — Duration: 3 yrs +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1300 E. Madison St Date signed 10.19

Rayner Browne X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 633140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 N. Collington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 N. Collington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel F. Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Paul Connolly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Wesley Canapp
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah V. Baseman
15. Birthplace Baltimore, Maryland

16 (a) Informant John W. Miller
(b) Address 1407 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cemetery
Location

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver Street

19 OCT 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3- 1942, to 10-19- 1945, and that I last saw her alive on 10-19- 1945.

Immediate cause of death	Duration
Coronary Occlusion	12 hrs
Due to Generalised arteriosclerosis	1942
Due to	
Other Conditions Diabetes Mellitus	1942

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fulton C. Craig M. D.
Address 7117 Belair Rd Date signed 10-20-45

94a

VS 190

G33141 Holste X ✓ G33141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5[illegible] Caroline Ave.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7726 Oakleigh Rd.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Holste

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna Holste

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/76

8. AGE: Years 68 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machine Operator.

11. Industry or business

FATHER 12. Name Frederick Holste

13. Birthplace Unknown

MOTHER 14. Maiden Name Mary C. Burgheimer

15. Birthplace Unknown

16 (a) Informant Anna E. Langlotz

(b) Address 7726 Oakleigh Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto Md

18 (a) Funeral director John C. Miller Inc.

(b) Address 2435 E. Oliver St

19 (a) Oct 20 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-45 19 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4/45 19 to 10/20/45 19, and that I last saw [illegible] alive on 10/20/45.

Immediate cause of death Cardio respiratory failure — Duration

Due to Gas Gangrene

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Amputation Left Leg

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Rodgers M. D.

Address St. Joseph's Hospital Date signed 10/24/45

VS 150

G33442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

Registered No. G33442

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caroline & Huffman

(c) Hospital or institution: St. Joseph's Hosp. 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 N. Bond St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME Hilary Anthony Fuchslugger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER

12. Name Joseph Frederick Fuchslugger

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Anna Dorothy Ruppel

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph Fuchslugger

(b) Address 1515 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director John C. Miller, Inc

(b) Address 2433 E. Oliver St.

19 (a) OCT 22 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1945 at 5:10 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1945 to Oct 21 1945 and that I last saw him alive on Oct 21 1945

Immediate cause of death	Duration
Atelectasis	
Due to Premature rupture of membranes	
Due to + Cord around neck	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank J. Ayd Jr. M. D.

Address W. Joseph Stroh Date signed 10/22/45

G33443

BALTIMORE CITY HEALTH DEPARTMENT ✓ G33443
CERTIFICATE OF DEATH 46F Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 Brookfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH HOBMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Rosa Hobman
(b) Address 2008 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem.
Location Wash. Blvd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) Date received OCT 22 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1945 at 5 38 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1945 to 10/21 1945 and that I last saw her alive on 10/21 1945.

Immediate cause of death Cardiac failure

Due to Hepatoma C metastases + extension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Daniel Hamburger M. D.
Address Sinai Hospital Date signed 10/21/45

VS 180

X

G33144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G33144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2539 Gaunt ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Lynch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife Joseph A. Lynch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1910

8. AGE: Years	Months	Days	If less than one day
35	7	23	hr. min.

9. Birthplace Baltimore Md
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Emiel Kime
	13. Birthplace Baltimore Md
MOTHER	14. Maiden Name Zoe Kitzinger
	15. Birthplace Petersburg Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Philbrook Lockie
(b) Address 1217 N Point St.

19 (a) OCT 22 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 21 1945 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1945 to 10-21 1945
and that I last saw her alive on 10-21 1945

Immediate cause of death Pulmonary Edema

Due to Paroxysmal Auricular Tachycardia

Due to Rheumatic Heart Disease, Inactive

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hudson G. Jones M.D.
Address Johns Hopkins Hosp. Signed 10/24/45

Benedict Stutzrube M.D.

VS 150

63345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

63345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 W. Lafayette Ave
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Sommers

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife JOHN GEORGE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 12, 1872

8. AGE: Years	Months	Days	If less than one day
73	8	7	hr. min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business OWN HOME

FATHER
12. Name JOHN W. KILLMOND
13. Birthplace Md.

MOTHER
14. Maiden Name LAURA V. WILLIS
15. Birthplace Md.

16 (a) Informant JOHN SOMMERS
(b) Address 2334 EDMONDSON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 22, 1945 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location BALTIMORE, Md.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 (a) OCT 20 1945 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1945, at 8.15 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to her death on the day stated above.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph B. Pollitt M.D.
Medical Examiner.
Date signed 10/20/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

YS 6

633446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 830 633446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3101 Garrison Blvd

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3101 Garrison Blvd

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lou L E Cole

3 (b) If veteran, name war No

3 (c) Social Security Account No. none

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife S Tipton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1. 1862

8. AGE: Years 81 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Cecil Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William McCullough

13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth McVey

15. Birthplace Md

16 (a) Informant Joseph E Cole

(b) Address 3101 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore Md

18 (a) Funeral director Wilson Colvin

(b) Address 1219 L Pont St

19 (a) Date rec'd by registrar OCT 22 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2d 1945 at 10 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Oct 20 1945 and that I last saw h[illegible] alive on Oct 19 1945

Immediate cause of death	Duration
Uraemia Coma	2 days
Due to apoplexy	4 days
Due to Hypertension, Senility	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation no

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence no at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Edward F Wells

Address 5776 Park Heights Date signed Oct 20 1945 M.D.

VS 150

BALTIMORE CITY HEALTH DEPARTMENT ✓ 633147
Registered No.

CERTIFICATE OF DEATH 108

633147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Reynold St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Howard Scott Allen

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-18-45

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl S. Allen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie Elaine Waddell
15. Birthplace Baltimore, Md.

16 (a) Informant Marie Allen
(b) Address 1436 Reynold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Finksburg Md

18 (a) Funeral director Millburn Funeral Dir
(b) Address 1217 E. Cold St

19 (a) (Date received by Registrar) OCT 22 1945 Registrar Huntington for Millburn

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 20, 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 18, 1945, to 10 - 20, 1945, and that I last saw h/M. alive on 10 - 20, 1945.

Immediate cause of death	Duration
Atelectasis of left lung	
Due to Obstruction of bronchus	
Due to Aspiration of food	
Other Conditions Lobar pneumonia, right lower lobe. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Atelectasis, pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Ehrlich M. D.
Address 1213 Light St. Date signed 10-20-45

114E

633:48

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

✓ 633:48 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Allendale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Ann Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1944

8. AGE: Years	Months	Days	If less than one day
1	7	20	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Malcolm A. Smith, Jr.
13. Birthplace Birmingham, Ala.

MOTHER
14. Maiden Name Mary Ann Graham
15. Birthplace Balto., Md.

16 (a) Informant Mr. William Graham
(b) Address Balto.

17 (a) Burial (b) Date thereof 10/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)
OCT 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19 1945 at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Strangulation.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/19/45 4:20 P.M.
(b) Where did injury occur? Strangulation - Neck
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Sleeping in Patented Garment

23. Signature Joseph B. McNally M.D.
Medical Examiner.
Date signed 10/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33149 ✓ X G33149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Rice Ave. - Catonsville
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME DONALD KIRK SQUIGGINS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1910

8. AGE: Years	Months	Days	If less than one day
35	2	10	hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business British Overseas Airways

FATHER
12. Name Edward K. Squiggins
13. Birthplace Ohio (Steubenville)

MOTHER
14. Maiden Name Gertrude T. Sanders
15. Birthplace Maryland (Balto.)

16 (a) Informant Mr. Edward K. Squiggins
(b) Address 1302 Rice Ave., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date received) OCT 22 1945 (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21, 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945, to Oct 21, 1945, and that I last saw him alive on Oct 21, 1945.

Immediate cause of death	Duration
Uremia	
Due to Chronic Glomerulonephritis with acute exacerbation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Kerpan M. D.
Address Franklin Square Hosp Date signed 10-24-45

633450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942 (Registered No.) 633450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 22 Athol Ave.

(c) Hospital or institution: General German Aged People's Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 22 Athol Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY SEEWALD

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	Male	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Philip Seewald

13. Birthplace Germany

MOTHER 14. Maiden Name Anna Martha Priester

15. Birthplace Germany

16 (a) Informant Mr. Henry Seewald

(b) Address Athol Ave., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/22/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) OCT 22 1945 (Date rec'd by registrar) (b)

Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19, 1945 at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1945 to Oct. 19 1945 and that I last saw him alive on Oct. 17 1945.

Immediate cause of death: Angina Pectoris — Duration: 12 days

Due to

Due to Coronary Embolism — Duration: unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Walds Schmidt M. D.

Address 933 Hanover Date signed Oct. 22 45

VS 180

G33451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 Q

Registered No. G33451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Cole St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2624 Cole St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Fowler Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 709 10 5323

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine M. Welling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 2, 1886

8. AGE: Years: 59 | Months: 7 | Days: 16 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Ass't Foreman

11. Industry or business Pullman Co.

FATHER
12. Name Samuel Fowler
13. Birthplace N. J.

MOTHER
14. Maiden Name Mary Ellen Dunn
15. Birthplace Md

16 (a) Informant Mrs Katherine Fowler
(b) Address 2624 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.22.45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Dorsey & Witzke
(b) Address 4101 Edmondson Ave

19 (a) OCT 22 1945 (b) Huntington Williamson, Md Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Oct 18 1945, and that I last saw him alive on Oct 18 1945

Immediate cause of death: Coronary occlusion — Duration:
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Shorofsky M.D.
Address 601 N. Monroe St Date signed M. 10 D. 20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33452

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3527 Old Frederick Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3527 Old Frederick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel H. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife E. Grace Harris nee Schaefer 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 28, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	21	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired Locomotive
11. Industry or business B. & O. R. R. Engineer

FATHER
12. Name John B. Harris
13. Birthplace Md

MOTHER
14. Maiden Name Hammond
15. Birthplace Md

16 (a) Informant Mrs E. Grace Harris
(b) Address 3527 Old Frederick Rd

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 22 45 (month) (day) (year)
(c) ~~Cemetery~~, or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Little
(b) Address 4401 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar

OCT 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1945, at 7:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941, to Oct 19 1945, and that I last saw h[illegible] alive on Oct 15 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 hr
Due to Arterio-sclerotic Hypertension	2 yrs
Due to Cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Colleran M. D.
Address 3521 Frederick Date signed 10-20-45

X

G33453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33453

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Elliott Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Hutchinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M. alias Hinecliffe

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8-1887

8. AGE: Years	Months	Days	If less than one day
58	8	10	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm Hutchinson
13. Birthplace Va.

MOTHER
14. Maiden Name anna Bradyhorse
15. Birthplace Baltimore

16 (a) Informant Mrs annie Robins
(b) Address 3215 Elliott St

17 (a) Burial (b) Date thereof 10/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Clarence F Hoffmann
(b) Address 1639 E Broadway

19 (a) (b)
OCT 22 1945 Huntington Nitkin M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1945, at 1 45 P M

21. I certify that I took charge of the remains described above, held an Inquest & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Fortune M.D.
Medical Examiner.
Date signed Oct 18 1945

633154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

633154 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Eggleton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mack Eggleton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 20 [illegible]

8. AGE: Years 43 | Months | Days 2L | If less than one day: hr. min.

9. Birthplace Evansville Ind (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mack Eggleton
(b) Address 1017 W Lanvale st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Balto Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

OCT 22 1945 (Date received by Registrar) (b) Huntington Williams, Md. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1945, at 7.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1945, to 10-20 1945, and that I last saw h e r alive on 10-20 1945.

Immediate cause of death Cerebral hemorrhage — Duration 12 hours

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Bagwell
Address Howard Hospital Date signed 10/22/45 M. D.

633455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1942

633455 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3629 Old York Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lorine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1890

8. AGE: Years	Months	Days	If less than one day
55	3	2	hr. min.

9. Birthplace Balto. Md. -
(Town, county, and state)

10. Usual Occupation Burler Foundry

11. Industry or business

FATHER
12. Name Henry B. Perry
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary E. Hamel
15. Birthplace Balto.

16 (a) Informant Lorine Perry
(b) Address 3629 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25 1945 (month) (day) (year)

(c) Cemetery or crematory Balto. Cemetery
Location North Ave -

18 (a) Funeral director Leonard J. Rucks
(b) Address 5305 Belford Rd -

19 (a) (Date received by Registrar) OCT 22 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 19 45 at 6 00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest on and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. J. Tubinski M.D.
Medical Examiner.
Date signed 10/22/45

X

G33456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G33456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Maderia St. Balto. Md. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Krol, James Anthony

3 (b) If veteran, name war ?

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Helen Louise Krol

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) [redacted], 1888

8. AGE: Years	Months	Days	If less than one day
56	11	25	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Robinson Oil Co.

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltor City

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 207 Eastern Ave

19 (a) (b)

OCT 22 1945

Huntington Whitestrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1945, at 12:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9 1945, to Oct. 20 1945, and that I last saw him alive on Oct. 20 1945.

Immediate cause of death Cardiac failure with mitral stenosis and pulmonary infarction — Duration 10/8/45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address U.S. Marine Hospital Date signed
Baltimore, Md.

633457 BALTIMORE CITY HEALTH DEPARTMENT 633457
Registered No.

CERTIFICATE OF DEATH 124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook + Caton Aves
(c) Hospital or Institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Mellon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Heine Andreae

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wife - Leona Keigler Andreae if alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 11-14-1879

8. AGE: Years 65 | Months 11 | Days 25 | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Real estate + mortgage
11. Industry or business Appraised + title atty

FATHER 12. Name Christian Andreae
13. Birthplace Germany
MOTHER 14. Maiden Name Henrietta Whitman
15. Birthplace Germany

16 (a) Informant Leona Keigler Andreae
(b) Address 48 Mellon Ave Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland Md.

18 (a) Funeral director Easton Sons Md.
(b) Address 608 Frederick Ave Catonsville Md.

19 (a) OCT 22 1945 (Date rec'd by registrar) (b) Signature [illegible]

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1945 at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1945 to 10-20 1945 and that I last saw alive on 10-20 1945

Immediate cause of death: Acute Heart failure C Circulatory Collapse. — Duration

Due to Massive Hemorrhages

Due to Ruptured Dysplazed Varices

Other Conditions Cirrhosis of Liver and Hemorrhoids C. Pdis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature [signature] M.D.
Address [illegible] Date signed 10/20/45

G33458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 93D

Registered No. G33458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens + Caton Ave

(c) Hospital or institution St Agnes Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto. Co. Ellicott City

(c) City or town Ellicott City

(If outside city or town limits, write RURAL and give town)

(d) Street No. Della Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Charles Howard Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mary Ethel Gordon

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1878

8. AGE: Years	Months	Days	If less than one day
67	—	25	hr. min.

9. Birthplace Md Carroll Co, Md.

(Town, county, and state)

10. Usual Occupation Brdge Bridge Operator

11. Industry or business

FATHER

12. Name Winfield Gordon

13. Birthplace Md.

MOTHER

14. Maiden Name Patience Brandenburg

15. Birthplace Md

16 (a) Informant Mrs Frank Jemonick

(b) Address Della Ave. Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1945 (month) (day) (year)

(c) Cemetery or crematory St. Johns Cemetery

Location Ellicott City, Md.

18 (a) Funeral director Easton Sons

(b) Address 608 Frederick Ave Catons Md.

19 (a) 22 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Oct 19 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1945 to 10-19 1945 and that I last saw h[illegible] alive on Oct 19 1945

Duration

Immediate cause of death Acute Cardiac Failure

Due to Coronary Thrombosis

Due to Arteriosclerotic C-V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address St Agnes Hosp Date signed Oct 19 46

G33459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 E. Hoffman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Virginia Robinson

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M.

6 (b) Name of husband or wife Geo. J.
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) May 7 1863

8. AGE: Years	Months	Days	If less than one day
82	5	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jermiah Fritel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaretta Seippel
15. Birthplace Baltimore

16 (a) Informant Helen R. Kauffman
(b) Address Drexel Hills Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

(a) (b)
Registrar

OCT 22 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1945, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945, to Oct 20 1945, and that I last saw h alive on Oct 20 1945.

Immediate cause of death	Duration
Bronchio Pneumonia	7 Days.
Due to	
Chronic Cardio Vascular Disease	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 2005 E. Monument St. Date signed

3654683460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13R 633460 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ciro Acanfora ACANFORA

3 (b) If veteran, name war

3 (c) Social Security Account No. 179-09-7891

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Barbara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1901

8. AGE: Years	Months	Days	If less than one day
44	2	24	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Drill press operator
11. Industry or business

FATHER
12. Name Jerry Acanfora -
13. Birthplace Italy

MOTHER
14. Maiden Name Phyllis Turi TURI
15. Birthplace Italy -

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Oct. 24 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location Mahanoy City Pa.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St. Baltimore Md.

19 (a) (b) Received by registrar Huntington Williams, M.D. Registrar
22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1945 at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1945 to Oct 21 1945 and that I last saw him alive on Oct. 21 1945

Immediate cause of death Anthracosilicosis
Bilateral Pulmonary tuberculosis & exudation

Due to

Due to

Other Conditions Anthracosilicosis
? cor Pulmonale
(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil E. Wilmer
Address Johns Hopkins Hosp Signed 10/21/45 M. D.

G33461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58 B Registered No. G33461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 17 E. Ostend St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto Co

(If outside city or town limits, write RURAL and give town)

(d) Street No. 17 E. Ostend St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Josephine D Ingrassia

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1931

8. AGE: Years	Months	Days	If less than one day
14		5	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Student

11. Industry or business St Marys School

FATHER

12. Name Joseph D Ingrassia

13. Birthplace St Louis Mo

MOTHER

14. Maiden Name Anna Rechiso

15. Birthplace N.Y.

16 (a) Informant Joseph D Ingrassia

(b) Address 17 E Ostend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Balto Md

18 (a) Funeral director A Howard Evans

(b) Address 1400 Charles St

19 (a) Registered Washington Williams, M.D. Registrar

OCT 22 1945

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1945 6 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Oct 20 1945; and that I last saw h[illegible] alive on Oct 20 1945.

Immediate cause of death	Duration
Endocarditis	
Due to	
Due to	
Other Conditions Acute Rheumatic Fever	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John G Schmunk

Address 1337 S. Charles St Date signed 10/21/45

X

G33462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1700 Block E. Monument st

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 554 W. Barre st (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oscar Meyerson,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ada Meyerson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1890

8. AGE: Years 55 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business grocries Store

FATHER 12. Name Unknown

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs. Ada Meyerson

(b) Address 554 W. Barre, st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rosedale

Location Philia Rd & Hamilton ave

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1194-96 W. North Ave

19 (a) 10-22-1945 (Date received by registrar) (b) Registrar

Huntington Williamsville, Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1945, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1945, to 10-21 1945, and that I last saw him alive on 10-21 1945.

Immediate cause of death Myocardial Infarction — Duration

Due to Coronary Occlusion

Due to Arteriosclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Jerome P. Bartsen M. D.

Address Sinai Hospital Date signed 10/22/45

X

633463 633463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) 9th Wd. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

G 33885

3 (a) FULL NAME Sylvia Nathan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Louis Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~11~~ 8.15.12

8. AGE: Years	Months	Days	If less than one day
33	2	7	hr. min.

9. Birthplace U.S. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name David Gerchman
13. Birthplace Russia

MOTHER 14. Maiden Name Esther Griesdorf
15. Birthplace Russia

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Columbus Ohio
Location Columbus Ohio

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date received by registrar OCT 22 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1945, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1945 to 10-22 1945, and that I last saw h alive on 10-22 1945.

Immediate cause of death general [illegible]

Due to metastatic carcinoma in lungs,

Due to primary in breast

Other Conditions Pregnancy
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

Duration
5 mos.
3 yrs.
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R Miller M. D.
Address Johns Hopkins Hosp Date signed 10-22-45

X

G33464

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

G33464
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4505 Kathland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Kathland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Fay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Leon Fay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24/1875

8. AGE: Years 69 | Months 10 | Days 28 | If less than one day: hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kelshaw
13. Birthplace England

MOTHER
14. Maiden Name Brown
15. Birthplace England

16 (a) Informant Charles F. Fay
(b) Address 4505 Kathland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24/1945 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Cumberland Md

18 (a) Funeral director Harry H. Armacost
(b) Address 4204 Ridgewood Ave

OCT 22 1945 (Date received by Registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1945 at 830 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/10 1943 to 10/21 1945 and that I last saw h-er alive on 10/21 1945.

Immediate cause of death: Coronary Occlusion — Duration: 3 days

Due to: Arterio Sclerosis — 4 yrs.

Due to:

Other Conditions: Carcinoma breast with metastasis — 3 yrs.
(Include pregnancy within 3 months of death)

Date of operation 2/25/43

Major findings of operation: Carcinoma of breast

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Edw M. D.
Address 3403 Parkside Blvd Date signed 10/22/45

G33465 48 [illegible] 58 BALTIMORE CITY HEALTH DEPARTMENT G33465
CERTIFICATE OF DEATH 35E
Registered No.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Annes Co.
(c) City or town Queenstown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sally Jane Listes
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-42

8. AGE: Years	Months	Days	If less than one day
3 yrs.	-	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bishop Listes
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/21/45 (month) (day) (year)
(c) Cemetery or crematory
Location Centreville, Md

18 (a) Funeral director Barton Bro.
(b) Address Centreville, Md.

19 (a) (Local registrar) (b) Registrar

OCT 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1945, at 3:37 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1945 to 10-21 1945; and that I last saw her alive on 10-21 1945.

Immediate cause of death: Right Eye Retinoblastoma with Extension to Right Temporal Lobe.
Due to: and frontal Lobes.
Due to:
Other Conditions: Terminal
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Anderson M. D.
Address Johns Hopkins Hosp. Date signed 10-22-45

Huntington Williams, M.D.

G33466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G33466

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution:

The Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 405 Colvin Street (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Johnson

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 12, 1945

8. AGE: Years	Months	Days	If less than one day
			6 hr. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER

12. Name John Johnson

13. Birthplace District of Columbia

MOTHER

14. Maiden Name Martha Marshall

15. Birthplace Maryland

16 (a) Informant Hospital Records

(b) Address .....

17 (a) ..... (b) Date thereof ..... (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....

Location .....

18 (a) Funeral director .....

(b) Address .....

19 OCT 22 1945 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

OCT 22 1945

Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1945, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 12 1945 to October 12 1945, and that I last saw him alive on October 12 1945.

Immediate cause of death asphyxia atelectasis

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

.....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Gilbert J. Vosburgh M. D.

Address Johns Hopkins Hosp. Date signed 10-16-45

VS 150

F-3032

G33467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 22 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Baby Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-45

8. AGE: Years	Months	Days	If less than one day
			8 hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Alexander Faulkner
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Bernice Hall
15. Birthplace Balto. Md.

16 (a) Informant Bernice Faulkner
(b) Address 1122 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 22 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) OCT 22 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8-1945, to 10-8-1945, and that I last saw him alive on 10-8-1945, 4 P.M.

Immediate cause of death

Prematurity — Duration 6 hrs.

Due to

Due to

Other Conditions Atelectasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Louise Young M. D.
Address 1102 Druid Hill Ave Date signed 10/19/45

VS 150

3031

G33468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/160a

Registered No. G33468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fremont + Greene
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Fremont St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy O'Bannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard O'Bannon
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Golden
15. Birthplace Phila., Penn.

16 (a) Informant Mother
(b) Address 605 Fremont St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 22 1945

18 (a) Funeral director Commissioner of Health
(b) Address

1945 OCT 22 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1945, at 4 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1945 to 10-18 1945 and that I last saw him alive on 10-18 1945.

Immediate cause of death Intracranial hemorrhage

Due to Encephalitis Febrilis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George M. Simons M. D.
Address Univ. Hosp. Date signed 10-18

VS 180

3030

G33469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
504 S.Clinton Street
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 11
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S.Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles (Karl) Epple

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 213-03-9290

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Epple
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.25.1873

8. AGE: Years	Months	Days	If less than one day
71	10	25	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business - Meat packing

FATHER
12. Name Frederick Epple
13. Birthplace Germany

MOTHER
14. Maiden Name Dora -------
15. Birthplace Germany

16 (a) Informant Mrs. Dora Epple
(b) Address 504 S.Clinton St.

17 (a) Burial (b) Date thereof Oct.23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (b)
OCT 22 1945 Huntington Millwood, Md.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.19.1945 19 at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1945 to 10-19 1945.
and that I last saw h[illegible] alive on 10-18 1945.

Immediate cause of death Coronary Thrombosis — Duration 28 days
Due to Arteriosclerotic heart — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. J. Davidow M. D.
Address 3218 Eastern ave Date signed 10-22-45

G33470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G33470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Ann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Gray

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Alfred Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1863

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	3	23		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ----Hall
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Mrs. Virginia Smith
(b) Address 15 N. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (Date rec'd by registrar) OCT 22 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1945 to Oct. 21 1945, and that I last saw h[illegible] alive on Oct. 19 1945

Immediate cause of death	Duration
Coronary Artery Disease	?
Due to Generalized Arteriosclerosis	1
Due to Senility	1
Other Conditions Cerebral artery disease	1 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Bal M.D.
Address 826 N. Washington St. Date signed Oct. 24, 1945

VS 150

1656-GB3471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G33471
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2555 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-?04

8. AGE: Years	Months	Days	If less than one day
41 40	3		hr. min.

9. Birthplace 7-?04. Wd. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Gross
13. Birthplace Wd

MOTHER
14. Maiden Name Rebecca ?
15. Birthplace Wd.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director Chas. H. Alexander
(b) Address 200 McCulloh St

19 (a) OCT 22 1945 (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1945, at 8 or A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1945 to 10-21 1945, and that I last saw h[illegible] alive on 10-21 1945.

Immediate cause of death Uremia — Duration 3 days

Due to Nephrosclerosis — Duration unknown

Due to Hypertension Cardiovascular Disease — Duration years

Other Conditions Diabetes Mellitus, Cirrhosis of Liver — Duration unknown
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Maxwell Williams M. D.
Address Johns Hopkins Hosp. Date signed 10-22-45

1310

G33472 BCH 34204 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

Registered No. G33472

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Male Bojarski (ANDREW HENRY BOJARSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-45

8. AGE: Years	Months	Days	If less than one day
0	0	10	hr. min.

9. Birthplace Doctors Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Army Bojarski
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Sawka
15. Birthplace Baltimore

16 (a) Informant
(b) Address 1909 Fleet St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S. Eaton St. Huntingtown Williamsport, Md

OCT 23 1945

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1945 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12- 1945 to 10-22 1945.
and that I last saw h alive on 19

Immediate cause of death	Duration
Syphilis Congenital	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Court Washington Post

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Klein M. D.
Address 876 Washington Blvd Date signed 10/23/45

X

G33473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G33473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 598 Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 598 Preston St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Melvin Butler

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-2492

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Yes

6 (b) Name of husband or wife: Lillian Butler

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1910

8. AGE: Years 35 | Months 8 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James D. Butler
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Rosa A. Cockey
15. Birthplace Balto Md

16 (a) Informant Mrs Mildred Thornton
(b) Address 1544 Penna Ave.

17 (a) V (Burial, cremation, or removal) (b) Date thereof 10-24-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto Md

18 (a) Funeral director J. L. Preston Leyton
(b) Address 579 Mosher St

19 (a) OCT 23 1945 Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1945 at 3:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Oct 20 1945, and that I last saw him alive on Oct 20 1945.

Immediate cause of death Tuberculosis of Lungs — Duration 1942

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey
Address 1928 Penna Ave Date signed 10/22/45 D.

X

G33474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

G33474 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Wyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Homer U. Todd, III

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1944

8. AGE: Years	Months	Days	If less than one day
1	7	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Homer U. Todd, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mabel E. Dyer
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Homer U. Todd, Jr.
(b) Address 612 Wyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Huntington Williams, M.D. Registrar

OCT 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1945, at 3:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1945 to Oct 22 1945 and that I last saw h[illegible] alive on Oct 22 1945

Immediate cause of death	Duration
Intracranial hemorrhage	
Due to Acute laryngo-tracheo-bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 21, 1945
Major findings of operation: Tracheotomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Candler M. D.
Address Maryland General Hosp. Date signed 10-22-45

G33475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 156

G33475 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address SINAI HOSP.
(c) Hospital or institution: MONUMENT ST.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town 1351 SARGEANT ST (If outside city or town limits, write RURAL and give town)
(d) ~~Street~~ city No. BALTIMORE MD (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY M. WALSH.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife JOHN J. WALSH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 1-1895

8. AGE: Years	Months	Days	If less than one day
50	1	21	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation CAR CLEANER
11. Industry or business BALTO TRANSIT. Co

FATHER
12. Name JAMES. OGDEN
13. Birthplace MD

MOTHER
14. Maiden Name JULIA. COLLISON
15. Birthplace MD

16 (a) Informant MRS JULIA PITTMAN
(b) Address 1121 BAYARD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct.-26-45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL CEM
Location BALTO MD.

18 (a) Funeral director BERNARD E. HARR
(b) Address 121 E WEST ST

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 23 1945 Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1945 to 10/22 1945 and that I last saw her alive on 10/22 1945.

Immediate cause of death Atelectasis (cont.) purulent bronchitis — Duration

Due to

Due to

Other Conditions cervical laminectomy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel Hamburger M. D.
Address Sinai Hospital Date signed 10/23/45

106 R

G33476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G33476

Registered No.

THESE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 Whatcoat St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	W. a. m. w. d

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Carter
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Maggie Stanush
15. Birthplace Fredericksburg, Va.

16 (a) Informant Helen Peterson
(b) Address 820 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.F. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 925 N. Mt. St.

19 (a) OCT 23 1945 (Date received by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1945, at 7.20 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mallory M.D. Medical Examiner.
Date signed 10/22/45

G33477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G33477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Diamond (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-12-1901

8. AGE: Years	Months	Days	If less than one day
44	-	10	hr. min.

9. Birthplace unknown (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name unknown

15. Birthplace

16 (a) Informant Geo Hill

(b) Address 406 Diamond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 24 (day) 45 (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna Ave

19 (a) Huntington Pittsburgh, Pa.

OCT 23 1945 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at 7 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1945, to Oct 22 1945, and that I last saw him alive on Oct 22 1945.

Immediate cause of death Generalized Peritonitis — Duration 24 hrs.

Due to Perforated Gastric Ulcer

Due to

Other Conditions Shock

(Include pregnancy within 3 months of death)

Date of operation Oct. 21, 1945

Major findings of operation: Perforation Peritonitis & Ascites

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Osmund Wiener M. D.

Address Univ. Hosp Date signed 10/23/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33478 X 94a Registered No. G33478

G33478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D. C. N.W. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 Ninth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Myles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mable Myles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-01

8. AGE: Years	Months	Days	If less than one day
44	8	11	hr. min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER
12. Name Joseph Miles
13. Birthplace Wash., D.C.

MOTHER
14. Maiden Name Anna Chase
15. Birthplace Washington, D.C.

16 (a) Informant Mable Miles
(b) Address 1920-9th St. N.W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lincoln Mem.
Location Suitland, Md.

18 (a) Funeral director Charles K. Law
(b) Address 805 Madison Ave

19 (a) OCT 23 1945 Huntington Maryland Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 19 45, at 10:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed October 22, 1945.

G33479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 a

Registered No. G33479

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah E Schuyard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John A Schuyard
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 30 1879
8. AGE: Years 65 | Months 10 | Days 1 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business At home
FATHER 12. Name John Walsh
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Sarah E McSweeney
15. Birthplace Baltimore Md.
16 (a) Informant Mrs John A Schuyard
(b) Address 927 W Baltimore St
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10 24 45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cathedral
Location 4300 Old Frederick Road
18 (a) Funeral director John E Conway & Son
(b) Address 901 N Gilmor St
19 OCT 23 1945 (Date received by local registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1945 at 6.45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 21 1945
and that I last saw h[illegible] alive on 10-21 1945

Immediate cause of death: Coronary thrombosis (occurred on 9-20-45)
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

Duration: 3 wks.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm B. Schneider M. D.
Address 541 Fulton Ave Date signed 10-22-45

VS 150

X

G33480

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G33480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 Leadenhall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Leadenhall (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lizzie Mills

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1885

8. AGE: Years 60 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Warrenington N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Watkins
13. Birthplace N C

MOTHER
14. Maiden Name Mary ?
15. Birthplace N C

16 (a) Informant Sarah Bowling
(b) Address 19 W Hill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) OCT 23 1945 (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/1945 at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Oct 18 1945; and that I last saw her alive on Oct 18 1945.

Immediate cause of death: Coronary Occlusion — Duration 4 days
Due to Cerebral Paralysis — 5 hrs
Due to Chronic Nephritis and Hypertension
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Gunn M.D.
Address 522 N. Arlington Ave Date signed 10/22/45

VS 150

G33481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33481 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Presbury St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Tegler.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed.
6 (b) Name of husband or wife: Herman A. Tegler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1865

8. AGE: Years 80 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business At home.

FATHER
12. Name John F. Carrill.
13. Birthplace England.

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. Harry A. Tegler.
(b) Address 2311 Montpelier Road.

17 (a) Burial. (b) Date thereof Oct. 24-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem'l
Location Woodlawn - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS OCT 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 22. 1945 at 5. A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1945 to Oct 22 1945 and that I last saw h[illegible] alive on Oct 22 1945

Immediate cause of death: Chronic Cardio Vascular disease — Duration 3 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Chas. W. Kalm M.D.
Address 1735 Pop Gr St Date signed 10/23/45

G33482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G33482 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CORA V. GERBIG — Emma Reed 645 Gay

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. NONE

4. Sex: FEMALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife John H Gerbig | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 - 1871

8. AGE: Years 74 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Co MD (Town, county, and state)

10. Usual Occupation HOME DUTIES

11. Industry or business

FATHER 12. Name STEPHEN DEAVERS
13. Birthplace Balto md

MOTHER 14. Maiden Name MARY SINGLETON
15. Birthplace BALTO md

16 (a) Informant MILDRED ROGERS
(b) Address 610 Scott St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Oliver
Location FREDERICK RD

18 (a) Funeral director Ambrose Inc
(b) Address 414 N Franklintown Rd

19 (a) OCT 23 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION 10-21-45

20. DATE OF DEATH Oct. 21st 1945 at 6:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15th 1940 to Oct 21st 1945 and that I last saw h-er alive on Oct. 21st 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Hale M. D.
Address 517 Scott St Date signed Oct 22/45

VS 150

Hunter Williams, M.D.

X

HEP #16076 G33483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G33483

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2 - 0

(e) Length of stay in Baltimore (yrs., mos., or days) 81-10- & 23

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1840 W. Pratt St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter G. Sadler or Saddler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1863

8. AGE: Years	Months	Days	If less than one day
81	10	23	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Sadler
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Welch
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 24 Oct. 45 (month) (day) (year)

(c) Cemetery or crematory Western Cem.
Location Edmondson Ave. Baltimore

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 W. North Ave.

19 (a) (b) Huntington Williams, M.D.
Registrar

OCT 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1945 at 9:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21, 1929 to Oct. 21, 1945, and that I last saw him alive on Oct. 21, 1945

Immediate cause of death: Acute congestive heart failure — Duration

Due to: arteriosclerosis

Due to:

Other Conditions: arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Eugene Adrian Patemiletta M. D.

Address B.C.H. Date signed 10-22-45

x Patemiletta

G33484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G33484 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Arunah Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward L. Smith

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife MARY V.

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Nov. 13-1945

8. AGE: Years	Months	Days	If less than one day
50 52	11	9	✓ hr. ✓ min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation MERT BUSINESS

11. Industry or business MARKET

FATHER
12. Name WILLIAM M. SMITH
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name CATHERINE MEISER
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. MARY V. SMITH
(b) Address 3030 ARUNAH AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT. 25-45 (month) (day) (year)

(c) Cemetery or crematory WOODLAWN CEMETERY
Location WOODLAWN, MARYLAND

18 (a) Funeral director CHESTER WEBER
(b) Address 2503 EDMONDSON AVE.

19 (a) (Signature of undertaker) (b) Huntingtown, Md.

OCT 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1945 at 1.05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 10/24/45

X

G333485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161 Q

G333485 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore - 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Mary Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JEAN MUEHLEISEN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-45

8. AGE: Years	Months	Days	If less than one day
			14 hr. 49 min.

9. Birthplace Church Home Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name CARL JOHN MUEHLEISEN
13. Birthplace NEW JERSEY (TRENTON)

MOTHER
14. Maiden Name REGINA MAY SCHNEIDER
15. Birthplace BALTIMORE MD.

16 (a) Informant CARL JOHN MUEHLEISEN
(b) Address 4509 Mary Ave., Balto - 6, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) OCT 23 1945 (Date received by registrar) Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1945 at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945 to 10-22 1945 and that I last saw her alive on 10-22 1945

Immediate cause of death: ATELECTASIS — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James B. Lansdale, M.D.
Address Church Home & Hospital Date signed 10-23-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G33486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G33486 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vaclava ABROMAITIS

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Br. Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known?

8. AGE: Years About 75? Months Days If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Vincenti Einarowicz
13. Birthplace Poland

MOTHER
14. Maiden Name Camillia Tomaszewski
15. Birthplace Poland

16 (a) Informant Anna Jaworsky
(b) Address 5616 Belair Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue

18 (a) Funeral director John A. Greblunchas Jr.
(b) Address 423 S. Paca St

19 OCT 23 1945 (Date rec'd by Reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1945 to 10-19 1945. and that I last saw h alive on 10-19 1945.

Immediate cause of death Nephritis
Uremia (Undetermined cause of nephritis) — Duration ?

Due to Hypertensive & arteriosclerotic heart disease — Duration 5 years

Due to Intestinal obstruction (paralytic) — Duration 7 Days

Other conditions

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation: Autopsy cloudy swelling & degeneration of Kidneys

Of autopsy Microscopic deferred.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Lat M. D.
Address Sinai Hosp Date signed 10-22-45
Balt md

VS 150

G33487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G33487

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah High

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John High

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1894

8. AGE: Years 51 | Months - | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Domestic.

11. Industry or business Home Wife.

FATHER
12. Name Bob Curtis
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John High
(b) Address 1305 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 25 45 (month) (day) (year)

(c) Cemetery or crematory ~~Mt Calvary~~
Location Arbutus Maryland Rt.

18 (a) Funeral director Elroy O Wilson

(b) Address 1000 Brantley ave

19 (a) (Date received by Registrar) (b) Huntington Williamsport

OCT 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22-45 1945 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20-1945 to 10-22-1945 and that I last saw him alive on 10-22-1945.

	Duration
Immediate cause of death Acute myocardits	1 day
Due to Bronchial asthma	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm L Dunn M. D.

Address 1420 E. Chase Date signed 10-22-45

X

633488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 E. Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Cook

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or Business

FATHER 12. Name John Jackson

13. Birthplace Va

MOTHER 14. Maiden Name Carnella Jackson

15. Birthplace Va

16 (a) Informant James H. Cook

(b) Address 1311 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brkut key ave

OCT 23 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 · 21 1945, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4 · 20 1945 to 10 · 21 1945 and that I last saw him alive on 10 · 21 1945

Immediate cause of death	Duration
Acute Pulmonary Congestion	10 D.
Acute myocarditis	10 D.
Due to Carcinoma Atonic Jejunal	6 mos.
Due to Carcinoma of breast	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Kelly M. D.
Address 1420 E. Chase Date signed 10 · 22 · 45

X

633489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 830

633489

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Hubbard Alley
(c) Hospital or institution: John Hopkins D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Hubbard Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza Barber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
C	F	M

6 (b) Name of husband or wife John Barber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant John Barber
(b) Address 427 N. Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) OCT 23 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1945, at 9:25 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. T. Lubenski M.D. Medical Examiner.
Date signed 10/22/45

G33490

WARMbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33490

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 / 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Warmbold

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1877

8. AGE: Years	Months	Days	If less than one day
68	8	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Retired - 15 yrs.

FATHER
12. Name Albert Warmbold
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary Wegman
15. Birthplace Baltimore Md.

16 (a) Informant Mr. George Warmbold
(b) Address 4203 Furley Avenue -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 23 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 20 1945, at 4.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1945 to 10-20 1945, and that I last saw him alive on 10-20 19 45.

Immediate cause of death	Duration
Cerebral Vascular accident	
Due to Hypertensive C.V.D.	
Due to	
Other Conditions Uremia, Pulmonary Tbc. - old.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp. Date signed 10-20-45

VS 150

G33491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH ELIZABETH WHEEDEN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Richard B. Wheeden
6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1838

8. AGE: Years	Months	Days	If less than one day
77	7 8	26	hr. min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Somerville
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Ellen G. Fisher
15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. H. Ford Wheeden
(b) Address 1525 E. 29th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 OCT 23 1945 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1945 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 45 to Oct 20 1945, and that I last saw her alive on Oct 20 1945.

Immediate cause of death: Cardiac failure — Duration

Due to Arteriosclerotic Cardio-vascular disease with hemiparesis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 10-22-45

VS 180

G33492

481441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1370

G33492 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glyndon.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Fuss.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife Margaret L. Fuss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-6-58

8. AGE: Years	Months	Days	If less than one day
87	1	16	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name J. John Fuss
13. Birthplace Md Africa

MOTHER
14. Maiden Name Hattie Ahler
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co.

18 (a) Funeral director J. F. Ellenstone
(b) Address Pikesville

19 (a) OCT 23 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-22 1945 at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-4 1945 to Oct-22 1945 and that I last saw him alive on Oct-22 1945

Immediate cause of death: Cerebral Anaemia — Duration: 9 hrs.
Due to: Post operative hemorrhage
Due to:
Other Conditions: Arterio sclerotic hypertensive Cardio vascular dis
(Include pregnancy within 3 months of death)
Date of operation 10/22/45
Major findings of operation: 2PH,
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Brendle M.D.
Address Johns Hopkins Hosp. Date signed 10/23/45

VS 150

G33493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G33493 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Amedore

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-076-537

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of ~~husband or~~ wife: Maria Amedore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1887

8. AGE: Years	Months	Days	If less than one day
58	5	10	hr. min.

9. Birthplace Aquile Italy (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business B.S.Co. SparrowsPoint Md.

FATHER
12. Name Bernardo Amedore
13. Birthplace Italy

MOTHER
14. Maiden Name Antonina Irti
15. Birthplace Italy

16 (a) Informant Maria Amedore (Wife)
(b) Address 34 N. Motford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dallahan
(b) Address 52 N. Morley St.

23 1945 Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH October 21, 1945, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1945, to Oct. 21, 1945, and that I last saw h im alive on Oct. 21, 1945.

Immediate cause of death: Carcinoma of stomach — Duration: Unknown

Due to

Due to

Other Conditions Metastasis

(Include pregnancy within 3 months of death)

Date of operation July 1945

Major findings of operation: Carcinoma of stomach Metastasis to liver.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philiano Artigiani

Address 2942 E. Fayette St. Date signed 10/22/45 M.D.

X

G33494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13B

G33494 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Barclay (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hazel Tinsley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Married

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - 2 - 21

8. AGE: Years	Months	Days	If less than one day
23			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Allen W Wing
13. Birthplace Va.

MOTHER 14. Maiden Name Cordelia Patterson
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co., Md

18 (a) Funeral director Mrs. Frances A. Hensley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS OCT 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1945 at 11 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945 to Oct 22 1945, and that I last saw her alive on Oct. 22 1945

Immediate cause of death: Tuberculous Pneumonia
Due to: Bilateral Pulmonary Tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: about one Week

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maxwell Williams M. D.
Address Johns Hopkins Hosp. Date signed 10-22-45

G33495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193E

Registered No. G33495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 W. mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 W. mulberry.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Mary Alice Reeves or Reed.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Spencer Reeves

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 15, 1887

8. AGE: Years 58 | Months 9 | Days 4 | If less than one day — hr. — min.

9. Birthplace Towson, Balto. Co. MD.
(Town, county, and state)

10. Usual Occupation Domestic Worker

11. Industry or business

FATHER
12. Name Benjamin Diggs
13. Birthplace Towson, MD.

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Towson, MD.

16 (a) Informant Louise Savage
(b) Address 608 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)
(c) Cemetery or crematory Oakmont Memorial
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 322 N. Schroeder St.

19 (a) OCT 23 1945 (Date received by Local Registrar) (b) Huntingtown Allegany MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 October 1945 at 7:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12.1.44 19 , to 10.19.45 19 , and that I last saw her alive on 10.19.45 19 .

	Duration
Immediate cause of death: Congestive Heartfailure	8.17.45
Due to: Myocarditis	12.1.44
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James M. Pair M. D.
Address 408 N. Carrollton Ave Date signed 10.30.45

VS 8

G33496 BALTIMORE CITY HEALTH DEPARTMENT G33496

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: M.P. Bernardo, Maryland Ave & 23rd St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Fayette Hotel Fayette St (If rural give location)
(e) Citizen of foreign country? 414 W. Fa (Yes or No) If yes, name country

3 (a) FULL NAME John J. McGinnis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Phila Pa (Town, county, and state)

10. Usual Occupation Warehouse Mgr

11. Industry or business

FATHER 12. Name Benjamin McGinnis
13. Birthplace Phila Pa

MOTHER 14. Maiden Name Mary A Haggerty
15. Birthplace Phila Pa

16 (a) Informant Charles Morris
(b) Address Phila Pa

17 (a) Removed (Burial, cremation, or removal) (b) Date thereof 10-23-45 (month) (day) (year)

(c) Cemetery or crematory Phila Pa
Location Phila Pa

18 (a) Funeral director George H. Farley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

OCT 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1945, at 8 15 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Oct. 18 1945

X

G33497 BALTIMORE CITY HEALTH DEPARTMENT G33497
CERTIFICATE OF DEATH 1111 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Sledge Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/22-1890

8. AGE: Years 55 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Littleton N. C. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Jackson Burgess
13. Birthplace North Carolina

MOTHER 14. Maiden Name Dollie Jones
15. Birthplace N. Carolina

16 (a) Informant Lillian McArthur
(b) Address 1424 E. Chase

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location Balto. County

18 (a) Funeral director Lottie Gross
(b) Address 1498 Ashland Ave.

19 (a) 10/23/1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1945 to Oct 22 1945 and that I last saw her alive on Oct 22 1945.

Immediate cause of death: acute pulmonary oedema — Duration: minutes

Due to heart failure — Duration: "

Due to hypertension — Duration: unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Zachary J. Lisk M.D. M.D.
Address 72 W. North Ave. Date signed 10/28/45

X

G33498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2642 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2642 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country 50 Years

3 (a) FULL NAME Michael Joseph Banahan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) Dec. 1882

8. AGE: Years	Months	Days	If less than one day
62	10		hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired- Bridge Dept.
11. Industry or business City of Balto.

FATHER
12. Name Thomas Banahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Agnes McLaughlin
15. Birthplace Ireland

16 (a) Informant Mrs. John Mooney
(b) Address 2642 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Filed) (b) by registrar Registrar

OCT 23 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1945, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1945, to Oct. 21 1945, and that I last saw him alive on Oct. 20 1945

Immediate cause of death: Hypertensive cardiovascular disease. — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Schmitz

Address 701 N. Kenwood Ave. Date signed 10/22/41 M. D.

X

G33499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

G33499

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Towson

(If outside city or town limits, write RURAL and give town)

(d) Street No. 237 Willow Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William J. Redmond

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mabel Blanche Redmond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace York Co Pa

(Town, county, and state)

10. Usual Occupation Farmer on Parrs Line

11. Industry or business

FATHER

12. Name Robert L. Redmond

13. Birthplace York Co Pa

MOTHER

14. Maiden Name Martha J Beck Tobb

15. Birthplace York Co Pa

16 (a) Informant Margaret Conner

(b) Address 237 Willow Av. Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1945 (month) (day) (year)

(c) Cemetery or crematory Maryland Memory Cem

Location Pikesville Md

18 (a) Funeral director C. T. Tuttle & Son

(b) Address Parkville Md.

Oct 23 1945 (a) (registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1945 at 8 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1945 to 10-23 1945 that I last saw him alive on 10-23 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. S. Robertson M. D.

Address St. Joseph Hosp. Date signed 10-24-45

G33500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106B

Registered No. G33500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 67 days
(e) Length of stay in Baltimore (yrs., mos., or days): ?

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1409 N. Rose St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Wessels, Morton Grant

3 (b) If veteran, name war: WW #1

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth Wessels

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sept. 30, 1888

8. AGE: Years: 57 | Months: - | Days: 22 | If less than one day: hr. min.

9. Birthplace: Fleetwood, Pa. (Town, county, and state)

10. Usual Occupation: upholster

11. Industry or business:

FATHER
12. Name: Augustus Wessels
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Ruth Gardner
15. Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: U.S. Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/26/45 (month) (day) (year)
(c) Cemetery or crematory: Rahms
Location: Baltimore, Md.

18 (a) Funeral director: Wilson Funeral Home
(b) Address: 1247 Ft Ave

OCT 24 1945
(a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 22, 1945, at 9:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1945, to Oct. 22 1945, and that I last saw him alive on Oct. 22 1945.

	Duration
Immediate cause of death: Chronic bronchitis with bronchiectasis	many years
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: U.S. Marine Hospital, Balto, Md.
Date signed: 10/23/45

VS 150

G33501 ✓ G33501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. .....

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Payson
(c) Hospital or institution:
West Baltimore General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town 1110 E North Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) FULL NAME Lillie A. Evans ✓

3 (b) If veteran, name war W
3 (c) Social Security Account No. nn
4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan 21 1870 1871
8. AGE: Years 74 ~~75~~ | Months 9 | Days 2 | If less than one day ..... hr. ..... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....
FATHER 12. Name John Wesley Evans
13. Birthplace Md
MOTHER 14. Maiden Name Mary L. Dix
15. Birthplace Md
16 (a) Informant Mary E. Schilling
(b) Address 1110 E North Ave
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10 25 25 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Tilhon Fox & Co
(b) Address 2017 Pont St
19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1925, at 12 35 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1925, to 10-23 1925, and that I last saw her alive on 10-23 1925.

	Duration
Immediate cause of death Cardiac failure	
Due to Left Ventricular failure	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Rudolf Friedmann M. D.
Address West Baltimore General Hospital Date signed 10-25-25

VS 150

(over) X

G33502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G33502

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Lexington St
(c) Hospital or institution: Aged Indigent & Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Lilburn

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9. 1864

8. AGE: Years	Months	Days	If less than one day
81	1	13	hr. min.

9. Birthplace St Mary's Co Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John Grey Lilburn

13. Birthplace

MOTHER 14. Maiden Name Mary Jane Biscoe

15. Birthplace

16 (a) Informant Aged Women's Home

(b) Address 1400 N Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director William Cookerne

(b) Address 1219 E Fort Ave

OCT 24 1945 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/45 19 , at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/ 19 38 to 10/22/ 19 45.
and that I last saw h im alive on 10/21 1945.

Immediate cause of death lobar pneumonia rt. — Duration 2 days

Due to

Due to

Other Conditions Chronic myocarditis generalized arterio-sclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B Jones M.D.
Address 11 E. Chase St., City Date signed 10/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 North Howard Street,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 North Howard Street,
(If rural give location)
(e) Citizen of foreign country? Born in U.S. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexander Hubley,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17th., 1850

8. AGE: Years	Months	Days	If less than one day
95	8	5	hr. min.

9. Birthplace Jackson Township, York Co., Pa.
(Town, county, and state)
10. Usual Occupation Merchant (Retired)
11. Industry or business General Merchandise

FATHER
12. Name George Hubley,
13. Birthplace York County, Pa.

MOTHER
14. Maiden Name Mary Harbaugh,
15. Birthplace York County, Pa.

16 (a) Informant Scott F. Free
(b) Address 2828 North Howard Street, (18)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Wolf's Cemetery,
Location Wolf's Church, York Co., Pa.

18 (a) Funeral director C. F. Koller.
(b) Address York, Pa.

Date received OCT 24 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1942 to Oct 22, 1945, and that I last saw him alive on Oct. 22, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 3 weeks
Due to Arteriosclerosis
Cardiac Vascular Lesions
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Weiss, M.D.
Address 1927 E. North Ave. Date signed 10/23/45

VS 150

X

G33504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

Registered No. G33504

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 Arunah Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Malcolm Grant

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Irmadell W. Grant
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1872

8. AGE: Years	Months	Days	If less than one day
73	9	9	hr. min.

9. Birthplace Knoxville, Tenn. (Town, county, and state)
10. Usual Occupation Tool Business
11. Industry or business Self

FATHER
12. Name John Grant
13. Birthplace Scotland

MOTHER
14. Maiden Name Amanda Russell
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Irmadell W. Grant
(b) Address 2543 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or cremetory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 24 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1945 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1945 to 10/22 1945 and that I last saw him alive on 10/22 1945

Immediate cause of death Coronary Thrombosis — Duration 5 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 10/22/45

VS 180

633505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

60

Registered No. 633505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Wyman Park Drive & 31st Sts.

(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 76 14

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md. (b) County:

(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 1806 Linden Ave. (If rural give location)

(e) Citizen of foreign country?: no (Yes or No) If yes, name country:

3 (a) FULL NAME: Tiller, Eula May

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Reginald L. Tiller

6 (c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1906

8. AGE: Years	Months	Days	If less than one day
39	-	25	hr. min.

9. Birthplace: Lynchburg, Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER

12. Name: Harry F. Watts

13. Birthplace: Va.

MOTHER

14. Maiden Name: Virginia May Driscoll

15. Birthplace: Va.

16 (a) Informant: Records

(b) Address: US Marine Hospital, Balto, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)

(c) Cemetery or crematory:

Location: Richmond, Va.

18 (a) Funeral director: Wm. J. TICKNER & SONS

(b) Address: Balto., Md.

OCT 24 1945 (Date rec'd by Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1945, to Oct. 23 1945, and that I last saw her alive on Oct. 23 1945.

Immediate cause of death: Adenocarcinoma, right breast, recurrent (primary removed on 2/10/44) with

Due to: metastases to right pleura, peritoneum, 3rd lumbar spine

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

Duration: 12-2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury:

23. Signature: John L. Wilson

John L. Wilson, Sr. Surgeon M. D.

Address: U.S. Marine Hospital, Balto, Md. Date signed 10/23/45

VS 150

633506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Sutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. Seminary Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jane Mattingly

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John Benjamin Mattingly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 / 9 / 1861

8. AGE: Years 84 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Charles County Md. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William C Dement
13. Birthplace Charles Co. Md

MOTHER
14. Maiden Name Eliza Wolfe
15. Birthplace Charles Co. Md

16 (a) Informant Mr. Donald E. Mattingly
(b) Address Walbert Apts., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Congressional Cem.
Location Washington, D. C.

18 (a) Funeral director C. Howard Tickner, Sr.
(b) Address Baltimore, Md.

OCT 24 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 22 1945 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1945 to 10/22 1945, and that I last saw h.e.r. alive on 10/22 1945.

Immediate cause of death	Duration
Antemortem Coronary Occlusion of Heart	1 hr.
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions Bronchopneumonia, Contributory	3 days

(Include pregnancy within three months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Compton

Address Hospital For Women Date signed 10/22/45 M.D.

633507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

633507 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Huffman
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Aliceanna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Prouty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1945

8. AGE: Years | Months | Days | If less than one day 1 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name William J. R. Prouty
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dakota M. nee Prouty
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. W. R. J. Prouty
(b) Address 1923 Aliceanna Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director C. J. Tenney & Son
(b) Address 1938 E. Lafayette Ave.

19 (Filed) OCT 24 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1945, at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1945 To Oct. 22 1945 and that I last saw her alive on Oct. 22 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Rubin, M.D.
Address 1408 N. Calvert Date signed 10/24/45

VS 180

G33508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Hoffman
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Aberwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Prouty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1945

8. AGE: Years	Months	Days	If less than one day
			4 hr. 35 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name William J. R. Prouty
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dolores Maria Breuning
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. W. Prouty
(b) Address 1923 Aberwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (a) OCT 24 1945 (Date rec'd by registrar) Municipality or Williams Wm. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1945, at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1945; to Oct. 23 1945, and that I last saw him alive on Oct. 23 1945.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene [illegible]

Address 1400 N. Caroline St. Date signed 10/23/45 M. D.

G33509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33509 Registered No. 832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Alice Hill Woodland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Tucumseh B. Woodland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 8, 1898

8. AGE: Years 47 | Months 3 | Days 12 | If less than one day hr. min

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Elegant M. Hill
13. Birthplace: Amelia, Va

MOTHER
14. Maiden Name: Lillie Lee
15. Birthplace: Baltimore, Md

16 (a) Informant: Tucumseh Woodland
(b) Address: 535 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 1945 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cem. Co.
Location: Baltimore Co. Md.

18 (a) Funeral director: Chas. H. Hyland
(b) Address: 1601 Druid Hill Ave

19 (a) (Date received by registrar) (b) Registrar

OCT 24 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20, 1945, at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945 to Oct 20 1945, and that I last saw h[illegible] alive on Oct 20 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to: Hypertension — Duration: 4 years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy?

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address 717 Madison Ave Date signed 10/24/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

633510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

633510

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town BALTO (If outside city or town limits, write RURAL and give town)

(d) Street No. 3023 Wolcott Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marks Weinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace London, England (town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER

12. Name Jacob —

13. Birthplace Poland

MOTHER

14. Maiden Name Fanny Ruth —

15. Birthplace Poland

16 (a) Informant Rose Weinberg

(b) Address 3023 Wolcott Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-45 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc

(b) Address 1739 E. Balto. St

19 (a) OCT 24 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1945, to 10-22 1945, and that I last saw him alive on 10-22 1945.

Immediate cause of death	Duration
Probable myocardial infarction	3 days
Due to Diabetes Mellitus	20 yrs.
Due to arteriosclerotic Heart Disease	5 yrs
Other Conditions Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operations 9-24-45; 10-15-45

Major findings of operation (1) amputation of 4th toe (2) mid-thigh amputation

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Arnold Katz M. D.

Address Sinai Hosp Balt. Md. Date signed 10-22-45

VS 150

G33511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

G33511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Panitz

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Washington D.C (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Cohen
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta
15. Birthplace Germany

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling St

18 (a) Funeral director Jos. C. Lewis Inc
(b) Address 1439 E. Baltimore St Huntington Williams, Inc.

19 (a) OCT 24 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1945 at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1945 to 10-23 1945.
and that I last saw h alive on 10-23 1945.

Immediate cause of death	Duration
Acute Myocardial infarction probable	15 min.
Due to A.S.H.D. - card dil + H. Aur. fibrill.	10 yrs.
Due to Cardiac decompensation multiple pulmonary infarctions	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arnall Katz M. D.
Address Sinai Hosp Date signed 10-25-45
Balt. Md

VS 150

G33512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

Registered No. G33512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: St. Paul & 23rd Sts
(c) Hospital or institution: Dr. Beck's
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mich. (b) County:
(c) City or town: Birmingham (If outside city or town limits, write RURAL and give town)
(d) Street No.: 935 Stanley- (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME: MILDRED C. ROWLES

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence J. Rowles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 13, 1903

8. AGE: Years: 42 | Months: 5 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Samuel M. Chenoweth
13. Birthplace: Md.

MOTHER
14. Maiden Name: Laura Wheeler
15. Birthplace: Md.

16 (a) Informant: Mr. Clarence J. Rowles
(b) Address: 935 Stanley, Birmingham, Mich.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/24/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

OCT 24 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1945, to Oct 23 1945, and that I last saw h[illegible] alive on Oct 23 1945.

Immediate cause of death: Pericarditis. Pleurites Peritonitis (fibrous)
Due to: Cause unknown
Due to:
Other Conditions: Pituitary Cachexia 6 mos. Eminent decease (?)
(Include pregnancy within 3 months of death)

Duration: 3 mo.

Date of operation:
Major findings of operation:
of autopsy: Pericarditis, Pleurites, Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harvey S. Beck M. D.
Address: St Paul & 23rd Date signed: 10/24/45

VS 150

G33513

REP #91680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1278

G33513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 9 & 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 -9 & 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 942 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Urban

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Genevieve Urban
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1887

8. AGE: Years	Months	Days	If less than one day
58	9	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Martin Urban
13. Birthplace Md.

MOTHER
14. Maiden Name Hattie Schreiber
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

OCT 24 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1945 at 6:15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 19, 1945 to Oct. 22, 1945 and that I last saw h im alive on Oct. 22, 1945

Immediate cause of death	Duration
Uremia	5 days
Due to Glomerulonephritis	6 days
Due to	
Other Conditions Gangrene - gall bladder	2 days?
Hip - Osteomyelitis	6 yrs.

(Include pregnancy within 3 months of death)

Date of operation 10-14-45
Major findings of operation: Gangrene - gall bladder
of autopsy yes + basic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hospitals Date signed 10-23-45

(Subject to Approval of Medical Examiner) Thomas J. Mercer, M.D.

VS 150

633514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 633514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore - 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Old Town Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Winkler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Johanna Winkler
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	15	hr. min.

9. Birthplace Charles Co. Md (Town, county, and state)
10. Usual Occupation Structural steel Worker
11. Industry or business

FATHER
12. Name Anthony Winkler
13. Birthplace Germany

MOTHER
14. Maiden Name Emily Adams
15. Birthplace Maryland

16 (a) Informant Mrs. John Sroka
(b) Address 5827 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

OCT 24 1945 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1945 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1945 to 10/21 1945, and that I last saw him alive on 10/21 1945.

Immediate cause of death: Adeno Carcinoma of Stomach — Duration

Due to: Pulmonary embolism

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/13/45

Major findings of operation: Carcinoma of Stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:-
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ray L. Clot, Jr. M. D.
Address Univ. Hosp. Date signed 10/21/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33515 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address MONUMENT St & RUTLAND AVE

(c) Hospital or institution: SINAI HOSPITAL 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State ~~Balt~~ Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1227 St. Mathews St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aaron Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married Widower

6 (b) Name of husband or wife Fannie Gordon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 86 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Rose Gordon

(b) Address 1227 St. Mathews St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1739 E. Balto St

19 (a) Date received OCT 24 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23 1945, at 3:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945, to 10-23 1945, and that I last saw him alive on 10-22 1945.

Immediate cause of death Cardiac failure — Duration

Due to Congestive failure

Due to HCVD Hypertension

Other Conditions Bronchial asthma Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Alvin D. Kuhn

Address Sinai Hospital Date signed 10-23-45 M. D.

VS 150

73D

G33516

AB-96602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Tessier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeannette Howzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- (26?

8. AGE: Years 26? Months ? Days ? If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name James Howzer
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Boyd
15. Birthplace S.C.

16 (c) Informant Baltimore City Hospitals-records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 24 1945

VS 15d

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20- 19 45 at 9.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10- 19 45 to 10-20 19 45
and that I last saw h alive on 10-20- 19 45

Immediate cause of death cerebral and subarachnoid hemorrhage

Due to Congenital Aneurism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address R E H. Date signed 10/22/45

633517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 192B

Registered No. 633517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 William St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 William St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Hyson.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-10-2623-A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Edna V. Hyson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1873

8. AGE: Years 72 | Months 8 | Days 12 | If less than one day: hr. min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual Occupation: umbrella driller
11. Industry or business: Cohen & Katz

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Minnie Freeman
(b) Address: 145 Jackson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-24-45 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Annapolis, Md.

18 (a) Funeral director: Chas. F. Dill.
(b) Address: 501 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D.

OCT 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Oct 24 1945 and that I last saw him alive on Oct 24 1945

Immediate cause of death: Apoplexy — Duration: 2 hrs
Due to: Mitral Regurgitation — Duration: Inf.
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature: W. H. Campbell M.D.
Address 1644 Eutaw St. Date signed 10-24-45

X

G33518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148 B

Registered No. G33518

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 E. Monument Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8713

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-84

8. AGE: Years	Months	Days	If less than one day hr.	min.
61	5	11		

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Clothing

FATHER
12. Name John Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie Johns
15. Birthplace Washington, D. C.

16 (a) Informant Minnie Miller
(b) Address 3019 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director Frederick D. Miller & Son
(b) Address 3019 E. Monument Street

19 (a) Date received OCT 24 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1945, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945, to Oct 23 1945, and that I last saw her alive on Oct 23 1945.

Immediate cause of death: Carcinoma of Uterus — Duration 2 yrs.
Due to
Due to
Other Conditions: Chr Arterio Sclerosis Hyper — 1 yr
Chr Secondary Anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F. Kavanaugh M.D.
Address 334 N. Calhoun St. Date signed 10-23-45 M. D.

VS 3

633519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

633519 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Frisby St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Homestead St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert G. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-6163

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth E Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Maintenance Dept.
11. Industry or business Penn. R. R.

FATHER
12. Name James S. Wilson
13. Birthplace Balto. Co

MOTHER
14. Maiden Name Charlotte Palmer
15. Birthplace Balto. Co

16 (a) Informant Mrs. Wilson
(b) Address 1710 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by Registrar) OCT 24 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22- 1945, at 7 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27- 1933, to 10-22- 1945, and that I last saw him alive on 10-22- 1945.

Immediate cause of death Cerebral Thrombosis — Duration 9 days

Due to Generalised arterio-sclerosis — 1933

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 10-23-45

2117 Belair Rd Dr Lang

G33520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33520 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2546 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2546 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Waesmus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Alberta L. Coston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1875

8. AGE: Years	Months	Days	If less than one day
69	10	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Store Monster.

FATHER
12. Name Charles F. Waesmus
13. Birthplace Maryland

MOTHER
14. Maiden Name —
15. Birthplace Maryland

16 (a) Informant Mrs Alberta L. Waesmus
(b) Address 2546 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry A Wilson
(b) Address 1101 Edmondson Ave

19 (a) 24 1945 (Date rec'd by registrar) Huntington Williams, M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1940 to Oct 22 1945, and that I last saw him alive on Oct 22 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 Days
Due to Cardio-Vascular Disease	5 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Coleman M. D.
Address 2432 Frederick Ave Date signed

VS 150

G33521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & 33rd Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Virginia Cassell

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec-3-1870

8. AGE: Years	Months	Days	If less than one day
74	10	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none - lived on income
11. Industry or business

FATHER
12. Name Charles E. Cassell
13. Birthplace Portsmouth, Va.

MOTHER
14. Maiden Name Sally Bowles
15. Birthplace Prince Edward Co., Va.

16 (a) Informant Mrs. W. R. Barkeley
(b) Address 1512 Park Ave., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove
Location Portsmouth - Va.

18 (a) Funeral director Steward Mortuary
(b) Address 108 W Mulberry

19 (a) (b) Registrar
(Date rec'd by registrar)
OCT 24 1945 Huntington Millerville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945 at 11:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1945 to Oct 22 1945 and that I last saw her alive on Oct. 22 1945

Immediate cause of death Cerebro-vascular accident (hemorrhage on left side) — Duration 1 day

Due to arterio-sclerotic heart disease, with hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Speed III M. D.
Address Union Memorial Hospital Date signed 10-22-45

G333522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G333522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town, write rural route or township and give name)
(d) Street No. [illegible] (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Sieling

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1891

8. AGE: Years	Months	Days	If less than one day
53	10	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Charles A Sieling
13. Birthplace Pa

MOTHER
14. Maiden Name Elizabeth Chenowith
15. Birthplace Balto Co Md

16 (a) Informant [illegible] Sieling
(b) Address [illegible]

17. Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milhorn & Sons Inc
(b) Address 1319 Edmondson Ave

19 (a) [illegible] (b) Huntington Williams, Md.
(Date received by registrar)

OCT 24 1945
VS 1ST

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1945 M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease
(Coronary)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Sabinski M.D.
Medical Examiner.
Date signed 10/24/45

633.523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

633.523 Registered No. 1124 B1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4503 Hosford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4503 Hosford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter S Gordon

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Freda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1892

8. AGE: Years 53 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Brooklyn N Y
(Town, county, and state)

10. Usual Occupation Engineer Mechanical
11. Industry or business Shipbuilding Co

FATHER
12. Name Ralph Gordon
13. Birthplace Bangor Maine

MOTHER
14. Maiden Name Harriett Fleeman
15. Birthplace Boston Mass

16 (a) Informant Wilborn G Ryan
(b) Address 4503 Hosford Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)
(c) Cemetery or crematory Evergreen
Location Brooklyn N Y

18 (a) Funeral director Wilborn G Ryan
(b) Address 1217 E Fort Ave

19 (a) (Date received by registrar) (b) Burlington Wisconsin

OCT 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1945 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 23 1945, and that I last saw him alive on Oct 22 1945.

Immediate cause of death Cirhosis of Liver — Duration 7

Due to

Due to

Other Conditions Endocarditis Mitral Valve — 9

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature H A Derby M D

Address 817 Medical Arts Bldg Date signed Oct 24/45

X

633.24

633.24

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 633.24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Men's & Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew W. Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1858

8. AGE: Years	Months	Days	If less than one day
87	9	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name James Henderson
13. Birthplace Md

MOTHER
14. Maiden Name Susan Bosley
15. Birthplace Md

16 (a) Informant Aged Women's & Aged Men's Home
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-23 1945, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15/ 1933 to 10/23/ 1945, and that I last saw him alive on 10/22/ 1945

Immediate cause of death: Myocarditis, chronic — Duration ? yrs.
Coronary insufficiency — ? yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B Jarrett M.D.
Address 11 E. Chase St., City Date signed 10/24/45

VS 150 OCT 24 1945

G33525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G33525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 N. Schroeder (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Samuel Taylor

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-24-1875

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Unemployed.
11. Industry or business

FATHER
12. Name Samuel Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Rachael Jones
15. Birthplace Md.

16 (a) Informant Pinkney Brown (Friend)
(b) Address 1405 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Chas. H. Hughes
(b) Address 512 N. Carrollton Ave.

19. Filed 10 24 1945 (Date filed by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/45, at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Fracture Femur.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 1 '45 at — M.
(b) Where did injury occur? Neck of Rt. Femur
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fall on floor

23. Signature Hugh B. McNally M.D. Medical Examiner.
Date signed 10/20/45

2 G33526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G33526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Bartlett Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bayard Heisel Heiry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Heiry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/1895

8. AGE: Years	Months	Days	If less than one day
50	2 0	14	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Edward Heiry
13. Birthplace

MOTHER
14. Maiden Name Lillian Heisel
15. Birthplace Delaware.

16 (a) Informant Mrs. Elizabeth Heiry
(b) Address 729 Bartlett Ave.

17 (a) Oak Lawn Cem. (Burial, cremation, removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location City

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 E. 32nd St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 24 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1945 at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1945 to Oct. 22, 1945, and that I last saw him alive on Oct 22 1945

Immediate cause of death	Duration
Biliary fistula + intestinal obstruction.	
Due to Gastric resection	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 10, 1945
Major findings of operation: Intestinal adhesions; acute gastritis.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul S. Casson M. D.
Address U. M. Hospital, Balto. Date signed 10-22-45

X

G33527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 Registered No. G33527

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2325 E. Monument
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 E. Monument st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Hirt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose M. Hirt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1895

8. AGE: Years 50 | Months 4 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Atty at Law

11. Industry or business

FATHER
12. Name Joseph J Hirt
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Peta
15. Birthplace Bohemia

16 (a) Informant Rose M. Hirt
(b) Address 2325 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bel Air Md

18 (a) Funeral director Frank Brockdon
(b) Address 900 N Gilmore St Baltimore, Md

19 (a) Oct 24 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1945, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 22 1945, and that I last saw h alive on Sept 2 1945

Immediate cause of death Coronary occlusion — Duration: sudden death

Due to Coronary arteriosclerosis — Duration: unable to state

Due to Hypertensive cardiovascular renal disease — Duration: 5 yrs. or more

Other Conditions gout

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard h. Tillman M.D.
Address 3035 St. Paul St Date signed Oct 23, 1945

VS 150

G33528

HKP # 96659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G33528

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 60- 8 & 7

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3540 Caton Ave., Zone 29 (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3 (a) FULL NAME: James Cornelius Thomas

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fannie Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1884

8. AGE: Years 60 | Months 8 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance Broker

11. Industry or business Self

FATHER

12. Name James Wilton Thomas

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Alice Reed

15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Md

18 (a) Funeral director Lee L. Sherwal

(b) Address 910 Frederick Avenue

OCT 24 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1945, at 9:10P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1945, to Oct. 22, 1945, and that I last saw him alive on Oct. 22, 1945

Immediate cause of death: Pulmonary Tuberculosis & Pneumonia, aspiration

Due to: supposed

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

Duration: 7

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.

Address Balto. City Hosp. Date signed 10/23/45

VS 150

633529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. 633529

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Osborne (Osborn)

3 (b) If veteran, name war	3 (c) Social Security Account No.
?	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day hr.	min.
73	2	?		

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

OCT 23 1945
Commissioner of Health

19 OCT 25 1945 (Date rec'd by registrar) Hunter Jon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 16 1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1945 to 10-16 1945 and that I last saw h[illegible] alive on 10-16 1945.

Immediate cause of death Heart failure coronary occlusion
Due to Coronary artery disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. F. [illegible] M. D.
Address Date signed

VS 190

3037 X

633530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 633530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 East Oliver Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 East Oliver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Laura Lord

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ---------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alphonso Lord
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 4-1874

8. AGE: Years	Months	Days	If less than one day
71 72	4	19	hr. min.

9. Birthplace Chicago Ill. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name John Kuhlmann
13. Birthplace Germany

MOTHER 14. Maiden Name Sarah Bouhle
15. Birthplace Chicago Ill.

16 (a) Informant Louis F. Lord
(b) Address 1703 East Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Ellsworth Almacost
(b) Address 3911 Liberty Heights Ave.
(c) Date received OCT 25 1945 (Registrar) Huntington Williams M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 22 1945, and that I last saw h[illegible] alive on Oct 22 1945.

Immediate cause of death	Duration
Chronic Congestive Heart Failure	
Due to Chronic Myocarditis	
Due to Chronic Nephritis	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Charles A Anderson M. D.
Address 3001 Shannon Drive Date signed

X

633531

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

944 Registered No. 633531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 North Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Erdman

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1876

8. AGE: Years	Months	Days	If less than one day
69	4	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wilhom H Erdman
13. Birthplace Md

MOTHER 14. Maiden Name Mary E McGlone
15. Birthplace Md

16 (a) Informant Mary E. Erdman
(b) Address 1831 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Sylvan Co Inc
(b) Address 1210 Park Ave

OCT 25 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1945 at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Oct. 23 1945

VS 151

G33532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 N. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 N. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Earville E. Hidey

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Henrietta J. Hidey
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	23	hr. min.

9. Birthplace Woodlawn Balto Co Md
(Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name Augustus Hidey
13. Birthplace Germany

MOTHER
14. Maiden Name Alice Upton
15. Birthplace Balto Co. Md.

16 (a) Informant Henrietta J. Hidey
(b) Address 2404 N. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Jno. W. Teufel & Son
(b) Address 801 N. Gayety St

19 (a) (b)
(Signature)
OCT 25 1945 Huntington Avenue, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1945, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1945 to October 23 1945 and that I last saw him alive on Oct. 23 1945

Immediate cause of death Cardio-Respiratory Failure

Duration

Due to Cerebral Hemmorhage

Due to Hypertensive - Arterio Sclerotic Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M.D.
Address 4 E. 33rd St Date signed Oct 23, 1945

G33533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45D

G33533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 S.STREEPER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL, and give town)
(d) Street No. 603 S.STREEPER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK SIEGRIST

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARY E.SIEGRIST
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.1 1887

8. AGE: Years 58 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation RETIRED FIREMAN
11. Industry or business BALTO.CITY FIRE DEPT.

FATHER
12. Name JACOB SIEGRIST
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name MARGARET HACK
15. Birthplace BALTO.MD.

16 (a) Informant MARY E.SIEGRIST (WIFE)
(b) Address 603 S.STREEPER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT.29/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly & Zeilenga
(b) Address 403 S.WOLFE ST.

19 (a) Received OCT 25 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT.24 19 45 at 3 AM

21. I certify that death occurred on the date above stated that I attended deceased from Feb. 19 45 to Oct 24 19 45
and that I last saw him alive on Oct 23 19 45

Immediate cause of death: Carcinoma of Lung (Primary) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G.B.Stevens
Address 3400 Eastern Ave Date signed 10/25/45

Huntington Williams, M.D.

VS 150

G33534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33534 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 N. Port St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence H. Seidensticker

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
U.S. Navy	219-03-2452	Male	White	married

6 (b) Name of husband or wife Anna L. Seidensticker
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 6, 1882

8. AGE: Years	Months	Days	If less than one day
63	3	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER 12. Name	Wm. Seidensticker
FATHER 13. Birthplace	Balto. Md.
MOTHER 14. Maiden Name	Elizabeth Sitzinger
MOTHER 15. Birthplace	Baltimore, Md.

16 (a) Informant Anna L. Seidensticker
(b) Address 1617 N. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor ave.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

19 (a) (b)
(Signature and address of registrar)
OCT 25 1945
Huntington Woodville, Md.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/45 at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1945 to 10-24 1945 and that I last saw h alive on 10-24-45.

Immediate cause of death
Due to Pneumonia
Due to Broncho Pneumonia
Due to Senility
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ted Runtz M. D.
Address 104 W. Mulberry St. Date signed 10-25-45

G33535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33535 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 South Lakewood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 South Lakewood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ana Belle Ulrich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lt Edward M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1877

8. AGE: Years 68 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Conrad Horst

13. Birthplace Germany

MOTHER 14. Maiden Name Christine Rose

15. Birthplace Germany

16 (a) Informant Edward M. Ulrich

(b) Address 629 S. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway.

19 (a) OCT 25 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/45 19 , at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 10/23/45

G33536 ✓ G33536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Lemmon Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfonso Strickland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1926

8. AGE: Years	Months	Days	If less than one day
19	4	7	hr. min.

9. Birthplace Siler City, N. C (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Strickland
13. Birthplace Siler City, N.C.

MOTHER
14. Maiden Name Sarah Davis
15. Birthplace Siler City, N.C.

16 (a) Informant Sarah Davis
(b) Address 1313 W. Lemon St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Siler City, N.C.
Location Greensboro, N.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar

OCT 25 1945 Huntington Fitzgerald, M.D.

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH October 20, 1945 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-20-45 at 9 P. M.
(b) Where did injury occur? (Dodson's Tavern) Furnace Branch Rd. near Gr
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Stabbing

23. Signature Carl D. Gratz M.D. Medical Examiner.
Date signed Oct. 22 1945

X

633537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 Q

633537 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 956 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Minnie Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1900

8. AGE: Years	Months	Days	If less than one day
45	1		hr. min.

9. Birthplace Rice Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Scott

FATHER 13. Birthplace Rice Va.

MOTHER 14. Maiden Name Ellen Fox

MOTHER 15. Birthplace Rice, Va.

16 (a) Informant Addie Foster

(b) Address 6 5-9 W. Mulberry St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10 (month) 30 (day) 45 (year)

(c) Cemetery or crematory Rice Va.

Location Farmville, Virginia

18. (a) Funeral director Mrs. Katie R. Walker

(b) Address 222 N. Schroeder St. Huntington, W. Va.

19 (a) OCT 25 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 19 45, at 5:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to Acute right ventricular dilatation.

Other Conditions Congestion of lungs, marked.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Shateralic M.D. Medical Examiner.

Date signed October 21, 1945.

VS 151

633538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

633538 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 26 Mallow Hill Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 26 Mallow Hill Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME MAMIE JANE CALVERT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife. –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1879

8. AGE: Years	Months	Days	If less than one day
66	8	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name William J. Calvert

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Annie R. King

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Fannie Schlick, sister

(b) Address 26 Mallow Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Baltimore, Md.

19 (a) Date received OCT 25 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22, 1945 at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 22 1945 and that I last saw h alive on Oct 22 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	6 yrs.
Due to Arteriosclerosis and Hypertension	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

Signature A. P. Van Schaick M. D.

Address 4818 Edmondson Ave Date signed 10/24/45

VS 150

633539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B2

633539 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1428 John St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1428 John St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NAOMI G. KIDD

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm. E. Kidd, Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1871

8. AGE: Years	Months	Days	If less than one day
74	2	4	hr. min.

9. Birthplace Catonsville, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry S. Gross

13. Birthplace Md.

MOTHER 14. Maiden Name Josephine Fieldmeyer

15. Birthplace -

16 (a) Informant Mrs. William Kidd, Jr.

(b) Address 618 Wicklow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) OCT 25 1945 (b) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1945, at 12:40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1945 to Oct 24 1945, and that I last saw h[illegible] alive on Oct. 22 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	2 mos
Due to Toxic nephritis	6 mos
Due to Generalized Arteriosclerosis	1 year
Other Conditions Chronic arthritis of multiple joints	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas F. White M. D.

Address 582 E. 22nd St Date signed 10/27/45

G33540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. 25th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVA GORSUCH WRIGHT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John T. Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1856

8. AGE: Years	Months	Days	If less than one day
89	6	17	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Gorsuch
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Miss Anna Taylor Wright
(b) Address 100 W. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 25 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1945, at 1:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Oct 23 1945, and that I last saw h[illegible] alive on Oct 21 1945

Immediate cause of death	Duration
Coronary occlusion	1 hr.
Due to Cardio-vascular-renal disease	10 yrs.
Due to Diabetes Mellitus	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Adam Dudderar
Address 846 W 36 St - Date signed Oct 24/45

VS 150

X

633541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

633541 Registered No.

163H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2137 Linden ave.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Temporary
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Linden ave. 3rd floor apartment
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph D. Chenowith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 - 1914

8. AGE: Years	Months	Days	If less than one day
31 30	1	29	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation physician & druggist
11. Industry or business

FATHER
12. Name George F. Chenowith
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Stallings
15. Birthplace Md

16 (a) Informant Mrs. Elizabeth Chenowith
(b) Address 3131 Orlands Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto Co.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1945, at 11 25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy & inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-23- at ? A.M.
(b) Where did injury occur? 2137 Linden ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas range - unlit burners

23. Signature Howard J. Claussen M.D.
Medical Examiner.
Date signed 10-23- 45

G33542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Light St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Bell Hooker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Married

6 (b) Name of husband or wife Benjamin A. Hooker 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
84	7	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home Maker

11. Industry or business

FATHER 12. Name James N. Easton

13. Birthplace Md

MOTHER 14. Maiden Name Do Not Know

15. Birthplace "

16 (a) Informant Mrs B. A. Hooker

(b) Address 313 Light St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director J. J. Fahey Home

(b) Address 1308 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180 OCT 25 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1945, to 10/23 1945, and that I last saw her alive on Oct 23, 1945.

Immediate cause of death General and cerebral arterio sclerosis — Chronic myocarditis

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deiler M. D.

Address 216 Hanover St. Date signed 10/25/45

X

633543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1441 Parrish St
(b) Street address
(c) Hospital or institution Balto Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) mo
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md (If outside city limits, write RURAL and give town)
(d) Street No. 1434 Parrish (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Horace Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Martha Harris
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 2 1891

8. AGE: Years 54 | Months 9 | Days 22 | If less than one day — hr. — min.

9. Birthplace N C (Town, county, and state)

10. Usual Occupation Mover

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Martha Harris
(b) Address 1430 Parrish

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. G. Nelson
(b) Address 1363 Presstman

19 OCT 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24-1945, at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16-1945 to 10-23-1945 and that I last saw h[illegible] alive on 10-23-1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 da

Due to Hypertension

Due to Chronic Gastritis

Other Conditions Bronchitis
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Wm R. Boykin M. D.
Address 1135 Eutaw Date signed 10/25/45

G33544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1192

Registered No. G33544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: University Hospt

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1024 W. Lombard St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Ernest Ritter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 23, 1940

8. AGE: Years	Months	Days	If less than one day hr.	min.
	6	1		

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Ernest Ritter

13. Birthplace Baltimore

MOTHER 14. Maiden Name Sadie Ryder

15. Birthplace Va

16 (a) Informant Mr Ernest Ritter

(b) Address 1024 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Baltimore Md

18 (a) Funeral director Chas S Condon & Son

(b) Address 901-03 Gilmor St

19 Date received OCT 25 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1945 at 1:53 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1945 to 10/24 1945.

and that I last saw h im alive on 10/24 1945.

Immediate cause of death	Duration
Sub-arachnoid hemorrhage	
Due to Acidosis	
Due to diarrhea	6 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard Green Shumway Jr M.D.

Address University Hosp Date signed 10/24/45

VS 180

G33545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G33545 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 Taplow Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 Taplow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Rutherford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	4	hr. min.

9. Birthplace New York (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Allen Rutherford
13. Birthplace N.C.

MOTHER
14. Maiden Name Marjorie Wolf
15. Birthplace N.C.

16 (a) Informant Allen Rutherford
(b) Address 332 Taplow Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-29-45 (month) (day) (year)
(c) Cemetery or crematory
Location Plattsburg N.Y.

18 (a) Funeral director John A. Mahon
(b) Address 3000 E. Baltimore St.

19 (a) OCT 25 1945 Interring from Williamsport, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1945, at 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Chronic pulmonary Tuberculosis with cavity formation; Tuberculous

Due to emphysema, left.

Other Conditions Congenital cyst of cerebellum.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed 10-25-45

VS 151

X

G33546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G33546 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 N. Linwood a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Linwood a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George M. Brunner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10 - 1889

8. AGE: Years 56 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired Police

11. Industry or business

FATHER 12. Name George Brunner
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Mary Lowder
15. Birthplace Baltimore Md.

16 (a) Informant Mary Brunner
(b) Address 532 N. Linwood av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rood.
Location Belair Rd.

18 (a) Funeral director John A. McJan
(b) Address 300 E Balto St.

19 (a) Filed by registrar (b) Registrar Huntington Williams, M.D.

Oct 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 Oct 24 1945 and that I last saw h[illegible] alive on Oct 23 1945

Immediate cause of death	Duration
Hypertensive cardio vascular renal disease	5 years
Due to	
Due to	
Other Conditions Carbol Thrombosis	1 day

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alex J. Sokorsky
Address 1929 N Eutaw St. Date signed Oct 25 45

X

G33547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 112 N. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RD and give town)
(d) Street No. 112 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara L. Command

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27-1880

8. AGE: Years 64 | Months 10 11 | Days 26 | If less than one day: hr. min.

9. Birthplace Poland. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Wm. Wasiak
13. Birthplace Poland

MOTHER — 14. Maiden Name Bradier
15. Birthplace Poland.

16 (a) Informant Thomas Command
(b) Address 112 N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Rd

18 (a) Funeral director John G. Moran
(b) Address 3002 E. Baltimore St.

19 (a) Oct 25 1945 (Date received by registrar) (b) Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23rd 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945 to Oct 23 1945 and that I last saw her alive on Oct. 23 1945

Immediate cause of death: Coronary Thrombosis — Duration: Oct 23/45
Due to: arterio-sclerosis + hypertension
Due to:
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumrein M. D.
Address 222 N. Belnord Ave Date signed

X Krumrein Oct 24/45

633548 264086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461 F

Registered No. 633548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1239 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Marshall.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-25-86

8. AGE: Years	Months	Days	If less than one day
59	4	27	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1691 Druid Hill Ave

19 (a) [illegible] (b) Huntington Williams, M.D.

OCT 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1945 at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1945 to Oct. 21 1945 and that I last saw her alive on Oct. 21 1945.

Immediate cause of death Carcinoma of liver

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
Weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Johns Hopkins Hosp Date signed Oct 22 45

G33549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G33549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6001 Walkhurst Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 6001 Walkhurst Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Abercrombie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Mary E. Dougherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 17 1855

8. AGE: Years	Months	Days	If less than one day
89	10	7	hr. min.

9. Birthplace Balto. Md. (State or country)
10. Usual Occupation Clerk (Retired)
11. Industry or business Balto. News Co.

FATHER
12. Name David Abercombie
13. Birthplace Scotland

MOTHER
14. Maiden Name Christine Taylor
15. Birthplace Scotland

16 (a) Informant Reginald Abercrombie
(b) Address 1909 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Balto.

18 (a) Funeral director E. J. Tammany & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to 1945, and that I last saw him alive on Oct. 19 1945.

Immediate cause of death Septic Pneumonia — Duration Immediate

Due to Senility — 2 yrs.

Due to Coronary Thrombosis — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations: ✓

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald T. Abercrombie M. D.
Address 10 Whitford Road Date signed Oct. 24/45

25 1945
Huntington Williams, M.D.

X

633550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. 633550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD. STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County CECIL
(c) City or town RISING SUN (If outside city or town limits, write RURAL and give town)
(d) Street No. RURAL (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country —

3 (a) FULL NAME MRS. MARY EDITH ADDISON HENRY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	MARRIED

6 (b) Name of husband or wife WILLIAM HENRY
6 (c) If alive, give age NOT KNOWN years

7. Birth date of deceased (mo., day, yr.) AUG. 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	2 —	24 —	— hr. — min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name WILLIAM ADDISON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name IDA E. HAINES
15. Birthplace MARYLAND

16 (a) Informant HUSBAND
(b) Address RISING SUN, MD.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Hanley Cemetery
Location Camden N.J.

18 (a) Funeral director J. E. Tyson.
(b) Address Rising Sun Md.

OCT 26 1945 (Registrar) Washington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 26, 1945 at 4:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 6, 1945 to OCT. 26, 1945, and that I last saw her alive on OCT. 26, 1945.

Immediate cause of death LYMPHO GRANULOMATOSIS - HODGKIN'S DISEASE — Duration

Due to —

Due to —

Other Conditions HYDRONEPHROSIS, LEFT. ARTERIOSCLEROSIS, GENERALIZED (Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm. D. Gamble M.D.
Address Union Mem. Hosp. Date signed 10/26/45.

VS 150

633551 ✓ 633551

482287.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Steinberg ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Harry.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6-15-81

8. AGE: Years	Months	Days	If less than one day
64	4	8	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Home-worker
11. Industry or business

FATHER
12. Name Moses Weinstein
13. Birthplace Russia

MOTHER
14. Maiden Name Rena
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location

18 (a) Funeral director J. A. Reina Inc
(b) Address 1439 E. Baltimore St

19 OCT 26 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-26 1945, at 1.35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945 to Oct 26 1945, and that I last saw h[illegible] alive on Oct 26 1945.

Immediate cause of death probable pulmonary embolism — Duration 2 hr.

Due to

Due to

Other Conditions bronchopneumonia — 2 wks.

(Include pregnancy within 3 months of death.)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 10-26-45

VS 150

111a Milnor

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution Lyndenhaven Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/42

8. AGE: Years: 2 | Months: 10 | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Magdalene Hall
15. Birthplace Baltimore, Md.

16 (a) Informant Hosp. Record
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 10 26 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorman Hill Rd

18 (a) Funeral director J. Fahey & Sons
(b) Address 1318 E. Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 OCT 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1945 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1945 to 10-29 1945, and that I last saw h. alive on 10-24 1945

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to Mediastinal Tuberculosis	
Due to healing	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Methelizah Spragins M. D.
Address Lyndenhaven Hosp. Date signed 10-29-45

G33553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yr 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Frederick Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A Gillen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Michael E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 16 1881

8. AGE: Years	Months	Days	If less than one day
64	8	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sebastian Hof
13. Birthplace Germany

MOTHER
14. Maiden Name Kate Sporf
15. Birthplace Maryland

16 (a) Informant Michael E Gillen
(b) Address 2005 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director George A Fahey
(b) Address Baltimore Fayette

19 (a) OCT 26 1945 (b) Filed by Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 19 45 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1943 to 10/24 1945.
and that I last saw h alive on 10/24 1945.

Immediate cause of death Hypertension — Duration 4 yrs
under immediate cause
Due to
Due to
Other Conditions Cerebral hemorrhage — 2 days
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2030 Wilkens ave Date signed 10/24/45

VS 150

X

G33554

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G33554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Bruns
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs.) mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 Bruns (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Lee Robinson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1904

8. AGE Years	Months	Days	If less than one day hr.	min.
41	8	13		

9. Birthplace Wilmington NC (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
12. FATHER Name Henry Clay Gold
13. Birthplace NC.
14. MOTHER Maiden Name Jenny
15. Birthplace N.C.
16 (a) Informant Edward
(b) Address 915 Bruns St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. co Md
18 (a) Funeral director Isaiah L. Brunston
(b) Address 108 W Montgomery St
19 (a) OCT 26 1945 (Date rec'd by registrar) for Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23/ 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1945 to Oct 23 1945 and that I last saw h.e.r. alive on Oct 22 1945.

Immediate cause of death	Duration
Bronchopneumonia (Cause undetermined)	3 mo.
Due to Patient refused X-ray and sputum tests.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert W. Jaines
Address 507 W. Hamburg St Date signed 10/26/45

VS 180

G33555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195 B

G33555 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Emory Featherberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	N	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-98

8. AGE: Years	Months	Days	If less than one day
47 49	1	7	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

MOTHER / FATHER

12. Name Charles Mines

13. Birthplace ?

14. Maiden Name Adeline Chambers

15. Birthplace Frederick Co. Md

16 (a) Informant Eleanor Letherbury

(b) Address 612 W. Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-45 (month) (day) (year)

(c) Cemetery or crematory Easton
Location Easton Md

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 108 N Monterey St Huntington Telephone, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1945, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945 to 10-24 1945 and that I last saw h[illegible] alive on 10-24 1945

Immediate cause of death Shock

Due to anesthesia N2O+O2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J L White M. D.

Address 1514 Division St Baltimore Md Date signed 10-25-45

X

G33556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. 665556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dlt
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Bevan St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Gomer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1894

8. AGE: Years	Months	Days	If less than one day
50 51	10	-	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank T Tyler
13. Birthplace Md

MOTHER
14. Maiden Name Mary Matthews
15. Birthplace Md

16 (a) Informant Bessie Crosby
(b) Address 212 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md

18 (a) Funeral director Isaiah L Brunsdon
(b) Address 108 W Montgomery St

19 (a) Date Received OCT 26 1945 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1945, at 9:20 AM

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis Degeneration

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D. Medical Examiner.
Date signed 10/30/45

633557

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47c

633557
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 East St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Cold Spring Lane W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Lennon JR.

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife: MYRTLE VIOLA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JAN 7, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	17	hr. min.

9. Birthplace: BALTIMORE, Md (Town, county, and state)
10. Usual Occupation: BOTTLER
11. Industry or business: NATIONAL BREWERY

FATHER
12. Name: GEORGE H LENNON SR.
13. Birthplace: VA.

MOTHER
14. Maiden Name: MINNIE EATON
15. Birthplace

16 (a) Informant: T. IRVIN LENNON.
(b) Address: 327 WESTOWNE Rd.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-27-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Co.
Location: Baltimore City

18 (a) Funeral director: Wm Gold Inc
(b) Address: 1217 St Paul Street

19 (a) (Date received by Registrar) (b) Registrar: Hunting for Williams

OCT 26 1945
VS YSY

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 24 1945, at 12:45 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bronchogenic carcinoma with metastasis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Benedict Skuteckis M.D. Medical Examiner.
Date signed 10-24-45

X

G33558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G33558

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital W 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 862 N. Howard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rosenstee/

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Claudia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1876

8. AGE: Years	Months	Days	If less than one day
69	7	16	hr. min.

9. Birthplace Wilkesbarre, Penna (Town, county, and state)
10. Usual Occupation Sprayer
11. Industry or business Enamel Shop Plant

FATHER
12. Name John H. Rosenstee/
13. Birthplace Emmettsburg Md.

MOTHER
14. Maiden Name Ellen Rudolph
15. Birthplace Emmettsburg Md.

16 (a) Informant William C. Rosenstee/
(b) Address 607 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory St Anthonys
Location Emmitsburg, Md.

18 (a) Funeral director Loring Byers
(b) Address 505 Park, Hagerstown

OCT 26 1945 (Date rec'd by local registrar) Hagerstown, Md. (Place)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 19 45 at 8:42 P M

21. I certify that I took charge of the remains described above, held an Autopsy on Inspection and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerot. & C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. A. Sulinski M.D. Medical Examiner.
Date signed 10/27/45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6335559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 6335559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 Clifton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Clifton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Edna Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George Webster
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) July 8, 1873

8. AGE: Years 72 | Months 3 | Days 17 | If less than one day: hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Home
11. Industry or business Home

FATHER
12. Name Lybrand Hufman
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Isabel Powell
15. Birthplace Pennsylvania

16 (a) Informant Mrs George Webster
(b) Address 2825 Clifton Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) Huntington Mills

OCT 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1945, at 9 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Oct 25 1945, and that I last saw her alive on Oct 24 1945.

Immediate cause of death Coronary Thrombosis — Duration: Began Oct 9 1945

Due to Arteriosclerotic Cardiovascular disease — Duration: 1 yr.

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation no operation

Major findings of operation:

of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joshua H. Armacost M. D.
Address 6719 W Belvedere Road Baltimore Date signed Oct 25 1945

D 33560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

D 33560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Penskie Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife late Martha J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13. 1862

8. AGE: Years	Months	Days	If less than one day
82	11	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name August Penskie
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Roland A. Penskie
(b) Address 2706 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Mitzie
(b) Address 4101 E Monument Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 26 1945 Lexington Millside, MD

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24/45 19 at 6.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 24 1945 and that I last saw h alive on Oct 23 1945.

Immediate cause of death Central Hemorrhage — Duration 5 days

Due to Hypertension

Due to Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Kermisch M. D.
Address 1934 Wilkens Ave Date signed

X

G33561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G33561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate
(c) Hospital or institution: Vendnor Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1374 W Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sams Cooke

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: J. Addison Cooke
6 (c) If alive, give age – years
7. Birth date of deceased (mo., day, yr.): Dec 12 1866
8. AGE: Years 78 | Months 10 | Days 13 | If less than one day, hr. min.
9. Birthplace: Beaufort S.C. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: J. Julius Sams
13. Birthplace: S.C.

MOTHER
14. Maiden Name: Mary Whittle
15. Birthplace: Virginia

16 (a) Informant: Conway W. Cooke (Son)
(b) Address: 3131 – P-St-N.W. Washington D.C.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-45 (month) (day) (year)
(c) Cemetery or crematory: Elmwood
Location: Norfolk Va.
18 (a) Funeral director: Stewart Morris Co
(b) Address: 1081 W Monk Ave.
19 OCT 26 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to 10/25 1945, and that I last saw her alive on 10/25 1945.

Immediate cause of death	Duration
Myocardial Infarct	4 days
Due to	
Due to	
Other Conditions: General Arterio sclerosis (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.R. Palagye M. D.
Address 326 Pendleton St Date signed 10/25/45

VS 180

G33562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 16 c

Registered No. G33562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkland & Rayner
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3049 Woodside Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Carey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 5 - 1945

8. AGE: Years | Months | Days: 20 | If less than one day: hr. min.

9. Birthplace: Balto (Town, county, and state)

10. Usual Occupation:
11. Industry or business: None

FATHER
12. Name William Harry
13. Birthplace Whitesford Md

MOTHER
14. Maiden Name Grace Albin
15. Birthplace Va.

16 (a) Informant: William Harry
(b) Address 3049 Woodside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 45 (month) (day) (year)
(c) Cemetery or crematory: Maryland Park
Location: Taylor Ave

18 (a) Funeral director: Mark W. E. Doggett
(b) Address: 710 Belair Rd

19 OCT 26 1945 (b) [illegible] Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1945, at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1945, to 10-25 1945, and that I last saw h[illegible] alive on 10-25 1945.

Immediate cause of death: Encephalitis
Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4 E Saratoga Baltimore Date signed 10-25-45

VS 150

633563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 633563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Hopkins Road - Balt Co
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Peter Mazza

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Mrs. Josephine Mazza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoe-maker
11. Industry or business

FATHER 12. Name Joseph Mazza
13. Birthplace Italy
MOTHER 14. Maiden Name Nancy Famulara (FAMULARA)
15. Birthplace Italy

16 (a) Informant Josephine Mazza
(b) Address 331 Hopkins Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by local registrar) (b) Huntington Williamstown, Md.

OCT 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/45 19 . at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 19 45 to 10-24 19 45 and that I last saw him alive on 10/24/45 19

Immediate cause of death Coronary Thrombosis — Duration 15 hrs
Due to Unknown
Due to
Other Conditions Chronic bronchitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. F. A. Steden Jr
Address Mercy Hospital Date signed 10/24/45
M. D.

A. F. A. Steden

633564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

633564
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dobrzycki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years	Months	Days	If less than one day
About 65	—	—	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Peter Dobrzycki
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Sophia Dobrzycki
(b) Address 117 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. city

18 (a) Funeral director Wm. S. Kalkowski
(b) Address 2007 Eastern Ave

19 (a) Oct 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1945, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection of Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Pulaski M.D.
Medical Examiner.
Date signed 10/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33565

HEP #96808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33565 Registered No.

119a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day

(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mos. 27 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore Dundalk

(If outside city or town limits, write RURAL and give town)

(d) Street No. 506 Wheeler Court, zone 22

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Diane Eleanor Shorter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1945

8. AGE: Years	Months	Days	If less than one day
	3	27	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Basil Shorter

13. Birthplace Md.

MOTHER 14. Maiden Name Ida Greenwood

15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10-26-45

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 3224 Schroeder St.

19 (a) Date received by registrar (b) Registrar Elsie Williams M.D.

OCT 26 1945

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1945 at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 1945 to Oct. 21, 1945 and that I last saw her alive on Oct. 21, 1945

Immediate cause of death Diarrhea

Duration 1 day

Due to exhaustion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Walter A. Leser M. D.

Address BCH Date signed 10-24-45

D33566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

D33566 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Community Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give location)

(d) Street No. 629 W Saratoga (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Montgomery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/45

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Community Hospital (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Tommy Fuller Montgomery

13. Birthplace Lynchburg S.C.

MOTHER 14. Maiden Name Fannie Belle Lacy

15. Birthplace Lynchburg S.C.

16 (a) Informant Fannie Montgomery

(b) Address 629 W Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1945 at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Oct 24 1945, and that I last saw him alive on Oct 24 1945.

Immediate cause of death	Duration
Carcinoma - Respiratory failure	
Due to Congestive Heart Disease	
Due to	
Other Conditions Agranulocytosis Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation Born Oct 16, 1945

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W M Scott M. D.

Address Community H. Date signed

VS 150

b 33567
633567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93)

Registered No. B-33567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 E Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 E Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand Lang

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary R Lang
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 21, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Restaurateur
11. Industry or business

FATHER
12. Name John J Lang
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Hartung
15. Birthplace Baltimore

16 (a) Informant Mary R Lang
(b) Address 2014 E Fayette St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 27 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location York Pa

18 (a) Funeral director Cullison Funeral Home
(b) Address 2104 Orleans St

19 OCT 26 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945, at 9:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1945 to Oct. 24 1945 and that I last saw h alive on 19

Immediate cause of death: Coronary Occlusion — Duration: Immediate

Due to

Due to

Other Conditions Arteriosclerosis Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Harry Linden M. D.
Address 14 E Lexington Date signed 10/24/45

VS 150

Approved: Robert A. Graham M.D. X

633568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 633568

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Edison Highway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Edison Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joseph L. Simmons

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Louise Simmons
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov 24 1876

8. AGE: Years	Months	Days	If less than one day
68	11	12	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Restaurateur
11. Industry or business

FATHER
12. Name Michael J Simmons
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hayes
15. Birthplace Ireland

16 (a) Informant Louise Simmons
(b) Address 1412 Edison Highway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cathedral Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 Orleans St

19 (a) (Date rec'd by registrar) OCT 26 1945 (b) Huntington Williams, M.D. (Registrar)
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1945, at 1 29 A M

21. I certify that death occurred on the date above stated that I attended deceased from 10/24 1945 to 10/25 1945 and that I last saw her alive on 10/25 1945

Immediate cause of death Chronic Adhesive Pericarditis
Due to Arteriosclerosis Myocardium
Due to Heart Failure

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Forrest F. Neuhauser M. D.
Address 1076 S. East Ave Date signed 10/26/45

633569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

633569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Muriel Golosko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/22/45

8. AGE: Years	Months	Days	If less than one day
	3	4	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Louis Golosko
13. Birthplace Russia

MOTHER
14. Maiden Name Celia Rusch
15. Birthplace Russia

16 (a) Informant Sam Rusch
(b) Address 321 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (month) (day) (year)
(c) Cemetery or crematory Mount Hebrew Cem
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Baltimore St Huntingdon Williamsport, Md

19 (a) OCT 26 1945 (Date rec'd by registrar) Registrar

Huntingdon Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/1945, at 8:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to 10/26 1945, and that I last saw h[er] alive on 10/26 1945.

Immediate cause of death Hydrocephalus

Due to

Due to

Other Conditions Bronchopneumonia, anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Schultz M. D.

Address Sinai Hospital Date signed 10/26/45

X

633570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

633570 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name of town)
(d) Street No. 1014 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Barbara Sydnor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/45

8. AGE: Years | Months: 2 | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name James Sydnor
13. Birthplace Va

MOTHER
14. Maiden Name Louise Jane
15. Birthplace Va.

16 (a) Informant James Sydnor
(b) Address 1014 E Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Baltimore Pike, Springfield, Md.

19 (a) OCT 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945 at 12 M. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diarrhea.
Dehydration, severe.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skaterelis M.D.
Medical Examiner.
Date signed October 25, 1945.

VS 151

Please write plainly, with pen or pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633571 ✓ 633571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2204 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Considine (Catherine Angela Considine)

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Considine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1908

8. AGE: Years 36 | Months 11 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Bickford Co.

FATHER
12. Name Frederick W. Foghtman
13. Birthplace Md.

MOTHER
14. Maiden Name Lenora May
15. Birthplace Md.

16 (a) Informant Louis Stein Inc.
(b) Address Cumberland Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 29/45 (month) (day) (year)
(c) Cemetery or crematory St. Peter and Paul Cem.
Location Cumberland, Md.

18 (a) Funeral director William J Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) OCT 26 1945 (Date received by local registrar) Huntingtor Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945, at 8:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Right sided heart failure

Due to Cor Pulmonale.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed October 26, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G33572 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4206 Orville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 N. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME John Frederick Buerhaus (Bruce)
3 (b) If veteran, name war
3 (c) Social Security Account No. 137-01-1211

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ethel (Heath)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30/1904

8. AGE: Years	Months	Days	If less than one day
41	3	23	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Firestone Tire Co.

FATHER
12. Name Charles Buerhaus
13. Birthplace Balto.

MOTHER
14. Maiden Name Emma Brompton
15. Birthplace Balto.

16 (a) Informant Mrs. Ethel Buerhaus
(b) Address 1020 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John S. Connelly
(b) Address 719 Eastern Ave. Tuly 21

19 (a) (Signature of registrar) (b) Registrar

OCT 26 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 23 1945, and that I last saw h alive on Oct 23 1945.

Immediate cause of death	Duration
Uremia	
Due to Chronic Nephritis	
Due to Nephrolithiasis	
Other Conditions Carcinoma Stomach Nephrectomy (Include pregnancy within 3 months of death)	

Date of operation Sept 1945
Major findings of operation Perforated Gastric ulcer Carcinoma Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams Buerhaus M. D.
Address Balto 6 Md Date signed 10/26/45

X

33573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 33573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 235 S Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 235 S Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Baranowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Herbut.
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant William Baranowski
(b) Address 3451 Mayfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 '41 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred N. Ozogynski
(b) Address 930 Eastern Ave

OCT 27 1941 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1941 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/7 1941 to 10/26 1941, and that I last saw h.e.r alive on 6/23 1941.

Immediate cause of death: Cardio-vascular renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Stone M. D.

Address 3215 Eastern Ave Date signed 10/26/41

VS 150

G33574 HEP #92586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G33574 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 - 7 - 20

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Whitecoat St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2

3 (a) FULL NAME Iola Griffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widowed

6 (b) Name of husband or wife Levi Griffin (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1915

8. AGE: Years	Months	Days	If less than one day
30	7	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Stevenson
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Coldetin (d)
15. Birthplace N. C.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location

18 (a) Funeral director Va Brooks
(b) Address 1443 N. Carey St

(a) OCT 27 1945 (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1945 at 12:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 15, 1945 to Oct. 25, 1945 and that I last saw her alive on Oct. 25, 1945

Immediate cause of death: Pulmonary Tuberculosis Bilateral Tuberculosis — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hubert B. Copeland Jr. M.D.
Address Balto. City Hosp. Date signed 10/25/45

VS 150

633575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

633575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C Hebner

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John C. Hebner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1870

8. AGE: Years	Months	Days	If less than one day
75	3	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Schiermyer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary C. Decker
15. Birthplace Md.

16 (a) Informant Mr. John A. Schaefer
(b) Address 1703 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) Huntington Williams M.D.
(Signature of registrar)
[illegible] 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1945 to 10-26 1945. and that I last saw her alive on 10-26 1945.

Immediate cause of death

Cardio-Respiratory Failure

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions Questionable Malignancy of spinal column

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St Joseph Hosp. Date signed 10-26-45

VS 196

X

633576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

633576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE HONEYWELL

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1855

8. AGE: Years 90 | Months 8 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired School Teacher

11. Industry or business Department Education Balto. City

FATHER
12. Name Charles Honeywell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. J. O. Honeywell
(b) Address New Amsterdam Bldg., Balto.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 27 1945 (Date rec'd by registrar) **(b)** Registered No. Huntington Woodstock, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 19 45 at 3 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 19 to Oct 25 1945 and that I last saw her alive on Oct 25 1945.

Immediate cause of death Gangrene of foot (Diabetes) — Duration: 2 mos

Due to Arterio-sclerosis — Duration: 10 yrs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Todd M. D.
Address 705 N. Fulton Av. **Date signed** 10/26/45

X

G33577 G33577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1608 N.Rutland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 N.Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H.McLaughlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Blanche Holland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	12	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Emma Mills
15. Birthplace Baltimore

16 (a) Informant Blanche McLaughlin
(b) Address 1608 N.Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1638 N. Broadway

19 (a) OCT 27 1945 Huntington Williamson
Filed rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1945, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Oct 26 1945, and that I last saw [illegible] alive on Oct 25 1945.

Immediate cause of death Cardio Vascular — Duration 7.
Due to Renal Disease
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph P. Kerrum
Address 2200 E Madison Date signed 10/27/45 M.D.

X

633578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 633578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2

(c) Hospital or institution: University Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4320 Old York Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Irene Barwick Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Geo. A. Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1900

8. AGE: Years	Months	Days	If less than one day
45 43	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER

12. Name Francis Wood

13. Birthplace Baltimore

MOTHER

14. Maiden Name Elizabeth Morgan

15. Birthplace Annapolis Md.

16 (a) Informant Geo. A. Jackson

(b) Address 4320 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)

(c) Cemetery or crematory Moreland Mem.

Location Taylor

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

19 (a) (Date received by Registrar) (b) Huntington Williams Registrar

OCT 29 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1945, at 1:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945, to Oct 23 1945. and that I last saw her alive on Oct 23 1945.

Immediate cause of death Subarachnoid Hem. Duration

1st. exposure Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J R McCurdy M.D.

Address Hosp. Date signed 10-29-45

X

633579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

633579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts.

(c) Hospital or institution: Univ. of Md. 28

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ~~Balto~~

(c) City or town Baltimore, City (If outside city or town limits, write RURAL and give town)

(d) Street No. 577 Old Orchard Rd. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mrs. May Hubbard Garrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	

6 (b) Name of husband or wife Dr. Joseph S. Garrison

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) 10/20/1870

8. AGE: Years	Months	Days	If less than one day
75	0	6	..... hr. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER — 12. Name Wm. Samuel Hubbard

13. Birthplace Caroline Co. Md. USA

MOTHER — 14. Maiden Name Sarah Wiley

15. Birthplace Caroline Co. Md. USA

16 (a) Informant Barbara Garrison

(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)

(c) Cemetery or crematory Spring Hill

Location Easton, Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) (b) Registrar

OCT 27 1945 Washington-Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1945 to 10/26 1945.

and that I last saw her alive on 10/26 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Degenerative cardio vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ——

Major findings of operation: ——

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Roy A. Cast, Jr. M. D.

Address Univ. Hosp. Date signed 10/26/45

X

G33580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 309 W. Lanvale St.

(c) Hospital or institution: 11-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)

(d) Street No. 309 W. Lanvale St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Tiltelbum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Tiltelbum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 60 ? | Months | Days | If less than one day hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Louis

FATHER 13. Birthplace Austria

MOTHER 14. Maiden Name Rose

MOTHER 15. Birthplace Austria

16 (a) Informant Mrs. Mary T. Tiltelbum

(b) Address 309 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/45 (month) (day) (year)

(c) Cemetery or crematory Lombardy Cemy.

Location Wilmington, Del.

18 (a) Funeral director John O. Mitchell Funeral

(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Burial Permit Number

OCT 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1945, to Oct. 22, 1945, and that I last saw him alive on Oct. 25 1945

Immediate cause of death: Heart failure

Due to: Old valvular heart

Due to: Arterio Sclerosis, Hypertension

Duration: a number of years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Garnefeld M. D.

Address 1821 Eutaw Place Date signed 10/29/45

X

633581 ROBINSON X 633581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 33a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Caroline
(c) City or town Federalsburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Beatrice Rahnson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/1945

8. AGE: Years | Months 8 | Days | If less than one day hr. min.

9. Birthplace Federalsburg (Caroline) Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Rahnson
13. Birthplace md

MOTHER
14. Maiden Name Evans
15. Birthplace md

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10 28 45 (month) (day) (year)
(c) Cemetery or crematory
Location Federalsburg,

18 (a) Funeral director J J Frampton Son
(b) Address Federalsburg Md

19 (a) Date rec'd by registrar OCT 27 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945, at 12 0/0 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1945, to 10/26 1945, and that I last saw h[illegible] alive on 10/26 1945.

Immediate cause of death Cardio Resp. Failure

Due to Meningitis

Due to Pneumonia

Other Conditions Rickets,

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Scott. M.D. M. D.
Address Community Hosp Date signed 10/27/45

VS 150

X

633582

633582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 75B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JONES HOPKINS HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hughes Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/1944

8. AGE: Years 1 | Months 14 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Baby none

11. Industry or business

FATHER
12. Name Granville Coleman
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Jones
15. Birthplace Md

16 (a) Informant Granville Coleman
(b) Address 1820 N Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 27 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1945, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945 to 10-25 1945, and that I last saw him alive on 10-25 1945.

Immediate cause of death: Septicemia with Secondary Stitch — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Anderson
Address Johns Hopkins Hosp Date signed 10-25-45

VS 150

633583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 633583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 N.Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N.Carrollton Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anna Wilson
3 (b) If veteran, name war No
3 (c) Social Security Account No. None
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Harry
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) 4/17/1897
8. AGE: Years 48 Months 6 Days 8 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jerry Williams
13. Birthplace S.C.

MOTHER
14. Maiden Name Caroline Nelson
15. Birthplace Md

16 (a) Informant Harry Wilson (Husband)
(b) Address 514 N.Carrollton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.
18 (a) Funeral director Charles G.Cooper
(b) Address 512 N.Carrollton Ave
19 OCT 27 1945 (b) [illegible] for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25/45 19 . at 9:00 AM
21. I certify that death occurred on the date above stated; that I last attended deceased from June 11 1945 to Oct 25 1945
and that I last saw he alive on Oct 25 1945

Immediate cause of death [illegible]
Duration 1 day
Due to Hypertension
Due to
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury
23. Signature L H Wells M. D.
Address 514 Carrollton Date signed 10/26/45

VS 150

633584

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92E

633584
Registered No. 298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 N. Carey St. 16
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N. Carey St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Carrie E. Wilson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Wm E. Wilson Sr.
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) June 8 1883 or 93

8. AGE: Years	Months	Days	If less than one day
52	9	16	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home

FATHER
12. Name John Strickland
13. Birthplace Maryland

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Wm. E. Wilson Jr
(b) Address 424 Fulton Ave Pimlico

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

Date received by registrar OCT 27 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24-1945 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1944 to 10-24 1945 and that I last saw her alive on 10-22 1945.

Immediate cause of death	Duration
Myocarditis	2 years
Due to	
Due to	
Other Conditions Nephritis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank E. Saunders M. D.
Address 2 W. Saratoga St Date signed 10-27-45

VS 150

X

633585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633585 520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Williamsport (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Walnut St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George T. Ritter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie H. Ritter
6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) 6-21-80

8. AGE: Years	Months	Days	If less than one day
68.71	4	6	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Jacob Ritter
13. Birthplace Pa.

MOTHER
14. Maiden Name Julia VanBuskirk
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-45 (month) (day) (year)
(c) Cemetery or crematory Wildwood
Location Williamsport Pa

18 (a) Funeral director Guy R. Bowers Jr
(b) Address 1512 Hollins St

19 OCT 27 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1945 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1945 to 10-27-1945 and that I last saw h[illegible] alive on 10-27-1945.

Immediate cause of death: Pulmonary Collapse
Terminal Pneumonia — Duration

Due to: Hypernephroma, rt, k.o.

Due to: with metastasis to

Other Conditions: Mental confl.
Ureteral calculus (Ts)
(Include pregnancy within 3 months of death)

Date of operation 8-5-45, 10-5-45

Major findings of operation: Inoperable metastatic lesion Upper Abd.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Boyce Jones M.D.
Address Johns Hopkins Hospital Date signed 10/27/45

VS 180

(OVER)

633586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 633586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5405 Grendon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5405 Grendon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Stewart Freburger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Elizabeth T.
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) March 28-1881

8. AGE: Years	Months	Days	If less than one day
64	6	29	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Western R. R.
11. Industry or business Bay Master

FATHER
12. Name Charles E. Freburger
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Davis
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth Freburger
(b) Address 5405 Grendon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-45 (month) (day) (year)
(c) Cemetery or crematory Maryland
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Ave
Penalty for false statement, Art. 43, Sec. 258, Code 1939

19 (a) [illegible] (b) [illegible] Registrar

OCT 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1945 to Oct. 27 1945 and that I last saw h in alive on Oct. 26, 1945.

Immediate cause of death	Duration
Carcinoma of descending Colon & Liver	5 Mos.
Due to	
Due to	
Other Conditions Mitral regurgitation.	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen G. Longewald M. D.
Address 1613 E. North Ave Date signed 10-27-

X

Dr. Gordy
6100 Bk. Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. 63358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Berkshrie Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Berkshire Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick J. Beck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ella G. Beck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Conrad Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Vaupel
15. Birthplace Germany

16 (a) Informant Mrs. Ella G. Beck
(b) Address 3202 Berkshire Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (Date rec'd by registrar) (b) Thurlington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1945 to Oct 26 1945.
and that I last saw h[illegible] alive on Oct 24 1945.

Immediate cause of death Cardio-Resp Failure
Due to Bronchopneumonia
Oct 10 & 20 1945
Due to
Other Conditions Advanced Arterio Sclerosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: none
of autopsy: No

Duration
6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury None

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 10/25/45

VS 150

633588

Dr. Kyle Golley
5100 Bk. Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. 633586

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Koester

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
male	white	married

6 (b) Name of husband or wife Margaret M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1865

8. AGE: Years	Months	Days	If less than one day
80	7	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Henry Koester
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Giles
15. Birthplace Germany

16 (a) Informant Mrs. Henry Beck
(b) Address 2502 Southern Avenue

17 (a) Burial (b) Date thereof 10-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

19 (a) OCT 27 1945 (b) Huntington for Hollingsworth
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to 10/24 1945
and that I last saw h alive on 10/24 1945.

Immediate cause of death Cardio-
Vascular Disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Kyle Golley M. D.
Address 5703 Harford Rd Date signed 10/25/45

VS 190

633589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

633589 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N.W. 16th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Akopian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-45

8. AGE: Years	Months	Days	If less than one day
	6.	6	hr. min.

9. Birthplace Fla. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Victor Akopian
13. Birthplace Med.

MOTHER 14. Maiden Name Ruby Woodin
15. Birthplace Kansas

16 (a) Informant JOHNS HOPKINS HOSP.
(b) Address

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Oct 27-45 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Edmiston Road.

18 (a) Funeral director John O Mitchell & Co
(b) Address 900 Eutaw Place

19 (a) (Date mailed by registrar) (b) Registrar

28 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1945 at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Oct 26 1945 and that I last saw him alive on Oct 26 1945.

Immediate cause of death? Pulmonary embolism?

Due to Infected cut down left ankle

Due to Malnutrition

Other Conditions Urinary infection, dysentery

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jim Monroney Jr. M. D.
Address Johns Hopkins Hosp. Date signed 10/26/45

633590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

633590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Parkton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Wells

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. 6 min. 7

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Wells.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Maryland.

16 (a) Informant Verna Wells.
(b) Address Parkton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31/45 (month) (day) (year)
(c) Cemetery or crematory Forest
Location Maryland.

18 (a) Funeral director Jacob Hartenstein
(b) Address Mount Freedom Pa.

19 (a) Oct 28 1945 (Date received by registrar) (b) Lexington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 19 45 at 2:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 19 45 to 10/28 19 45 and that I last saw him alive on 10/28 19 45.

Immediate cause of death Uremia & Heart Failure — Duration

Due to

Due to

Other Conditions Carcinoma of Prostate
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ca of Prostate

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. M. Parham M. D.
Address University Hosp. Date signed 10/29/45

633591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

633591 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 W 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 W 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John T. Minnick.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Martha J. Minnick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1857

8. AGE: Years	Months	Days	If less than one day
88	1	28	hr. min.

9. Birthplace Maryland (City, county, and state)
10. Usual Occupation Retired Gardener.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John W. Minnick
(b) Address 318 W 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29/45 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Balto Co, Md

18 (a) Funeral director C. Hungerford & Son
(b) Address 3615-17 Chestnut Ave.

19 (a) 10/28/1945 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1945 at 10 P.M.

21. I certify that death occurred on the date above stated, that attended deceased from June 17 1941 to Oct 26 1945 and that I last saw him alive on April 26 1945

Immediate cause of death: Chronic Myocarditis

	Duration
Due to	
Due to	
Other conditions: Senility Valvular Chronic Nephritis (Include pregnancy within three months of death)	

Date of operation
Major findings of operation
of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Richardson M.D.
Address 1120 W. 20th Date signed Oct 27/45

VS 150

G33592 ✓ G33592

BALTIMORE CITY HEALTH DEPARTMENT

Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Riggs Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Grollman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Solomon Grollman
13. Birthplace Russia

MOTHER
14. Maiden Name Etta ?
15. Birthplace Russia

16 (a) Informant Max Fisher
(b) Address 3760 Dolfiel Ave

17 (a) Burial (b) Date thereof Oct, 28, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 28 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 9.45

20. DATE OF DEATH October 26, 1945 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 19 45 to Oct 26 19 45.
and that I last saw h[illegible] alive on Oct 26 19 45.

Immediate cause of death Coronary thrombosis — Duration 1 Day

Due to

Due to

Other Conditions Cyst Fibroids — 1 week

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Grahman M D

Address 191 W Mount Royal Ave Date signed 10/27/45

VS 150

633.593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

633.593 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Hudson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2834 Hudson St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Thompson

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	212-16-5892

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Minnie M. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2nd. 1867

8. AGE: Years	Months	Days	If less than one day
78	1	24	hr. min.

9. Birthplace Chester Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Canton Lunber Co.

FATHER
12. Name Alexender Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Julia ---
15. Birthplace Md.

16 (a) Informant Mr. Wm. H. Thompson
(b) Address 2825 Hudson St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 29/45 (month) (day) (year)
(c) Cemetery or crematory Stevensville Cem.
Location Stevensville Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26/45 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Oct 27 1945, and that I last saw h. alive on Oct 27 1945.

	Duration
Immediate cause of death Chr. Myocarditis	7
Due to Bronchial Pneumonia	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidson M. D.
Address 3218 Eastern Ave Date signed 10-27-45

VS 150

X

633594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

633594 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 839 Mangold St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 839 Mangold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary L Seelbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Robert Seelbach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3. 1860

8. Age: Years 82 | Months 8 | Days 23 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John Hayden
13. Birthplace Va

MOTHER
14. Maiden Name Dont Know
15. Birthplace " "

16 (a) Informant Mrs Bessie Bryant
(b) Address 839 Mangold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/45 (month) (day) (year)
(c) Cemetery or crematory Parkham Baptist Cemetery
Interment Virginia

18 (a) Funeral director Wilson Gordon
(b) Address 2102 Pennsylvania Ave
(c) Huntington Williams, Undertaker

OCT 28 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945, at 5:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945, to Oct 26 1945, and that I last saw her alive on Oct 26 1945.

Immediate cause of death	Duration
Myocarditis	5 days
Due to	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Morley Hoag M. D.
Address 729 Washington Ave Date signed Oct 26/45

VS 150

THESE ITEMS FURNISH, WITH UNFAILING ACCURACY, information which is of the utmost importance to the living. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G33595 — Hans F. Deuchler — 46a — G33595

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Reisterstown Road
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Roslawway Branch (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jan F. Deuchler

3 (b) If veteran, name war — NV
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	M

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age 1887

7. Birth date of deceased (mo., day, yr.) June 15 [illegible]

8. AGE: Years	Months	Days	If less than one day
63	4	11	hr. min.

9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER — 12. Name Fred Deuchler
FATHER — 13. Birthplace Baltimore, Md
MOTHER — 14. Maiden Name Katherine Appel
MOTHER — 15. Birthplace Germany

16 (a) Informant John F. Deuchler
(b) Address 43 Rockaway Beach, Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilhelm Eckhardt
(b) Address 1219 E Fayette St

19 (a) 10-30-1945 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945 at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Oct 26 1945; that I last saw him alive on Oct 26 1945.

Immediate cause of death	Duration
Carcinoma of Esophagus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M.D.
Address Union Memorial Hosp Date signed 10-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

(over)

633596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

633596 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lauder & Madison

(c) Hospital or institution: Maryland General Hospital 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo 18 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1565 Caswell St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mae J Everett

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1915

8. AGE: Years 30 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Dover Delaware (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name John Myler

13. Birthplace Del

MOTHER

14. Maiden Name Elsie Unknown

15. Birthplace Unknown

16 (a) Informant George Everett

(b) Address 1565 Caswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)

(c) Cemetery or crematory Elkton

Location Elkton Md

18 (a) Funeral director Wilson Funeral Home

(b) Address 127 E Pond St.

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1945 at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1945 to 10/25 1945, and that I last saw h alive on 10-25 1945.

Immediate cause of death: Cachexia — Duration:

Due to: Lymphosarcoma

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 1st operation 6/12/45

Major findings of operation: Lymphosarcoma

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Gerard E Crane M. D.

Address Md. General Hospital Date signed 10/26/45

VS 150

X

633597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

633597

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1450 Montpelier Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1450 Montpelier Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTOPHER SPANGLER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 217-20-6517

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Widowed

6 (b) Name of husband or wife: Lillian Spangler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1868

8. AGE: Years	Months	Days	If less than one day
77	8	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business Foster Bedding Company

FATHER
12. Name John Spangler
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Sondergeld
15. Birthplace Maryland

16 (a) Informant Henry Spangler
(b) Address 1450 Montpelier Street

17 (a) burial (b) Date thereof 10/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 28 1945 (b) Clinton Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Oct 26 1945
and that I last saw h wife alive on Oct 20 1945

Immediate cause of death	Duration
Hypertrin Cardio vascular disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth L Kinzey MD
Address 2700 [illegible] Date signed 10/26/45 M. D.

X- Kinzey

VS 150

Please write plainly, with unfading ink. Entry of information should be extremely accurate. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

633598 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St & Rutland Ave

(c) Hospital or institution: Sinai Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 1D

(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs-

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3815 Fernhill Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME LOUIS ELET

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia (City, county, and state)

10. Usual Occupation Inspector

11. Industry or business A. C. W. of America

FATHER

12. Name Hyman-

13. Birthplace Russia

MOTHER

14. Maiden Name Ida-

15. Birthplace Russia

16 (a) Informant Marie Elet

(b) Address 3815 Fernhill Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-29-45 (month) (day) (year)

(c) Cemetery or crematory Chicago, Ill.

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1739 E. Balto St

19 (a) 10/29/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1945 to 10/27 1945

and that I last saw him alive on 10/27 1945

Immediate cause of death Pulmonary edema — Duration

Due to Disseminated carcinomatosis

Due to

Other Conditions Epidural abscess

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: at alone

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Daniel Hamburger M.D.

Address Sinai Hospital Date signed 10/27/45

VS 180

633:99

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

633:99 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days) 65

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Schwartz Mary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Morris Schwartz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Samuel Rudman
13. Birthplace Russia

MOTHER 14. Maiden Name Florence —
15. Birthplace Russia

16 (a) Informant Emanuel Schwartz
(b) Address 713 Carlton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-45 (month) (day) (year)
(c) Cemetery or crematory Edgewood Memorial Park
Location

18 (a) Funeral director Jack Evans Inc
(b) Address 1738 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1945, at 4:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Oct 25 1945, and that I last saw her alive on Oct 25 1945.

Immediate cause of death: myocardial failure — Duration

Due to coronary occlusion

Due to arterio sclerotic heart disease

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Scherlis M. D.
Address Sinai Hospital Date signed 10-25-45

VS 150

X

633500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 633500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address West Baltimore Gen. Hospital

(c) Hospital or institution: Druid and Layard Ave.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3532 Cottage Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Tillie Sievogell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Kalman Sievogel.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Russia 1885

8. AGE: Years 60yrs Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Samuel

13. Birthplace Russia

MOTHER 14. Maiden Name Elani

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cemetery

Location Old Frederick Road

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1439 E Balt St

19 (a) 10/28/45 (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945 at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1945 to 10-27 1945, and that I last saw her alive on 10-26 1945.

Immediate cause of death Respiratory failure

Due to Carcinomatosis of lungs.

Due to Carcinoma of bladder

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature James A. Doubles M. D.

Address 1001 Eutaw Pl Date signed 10/29/45

VS 150

X

S33601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163

G33601

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.D.A
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 "O" St. S.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Y. Lapidus

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife BEVERLY NEE MICHAELS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
28			hr. min.

9. Birthplace U.S.
(Town, county and state)
10. Usual Occupation Manager Drug Store
11. Industry or business

FATHER
12. Name Murray Lapidus
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Mrs. Beverly Lapidus
(b) Address 221 O. St. S.W. Wash. D.C.

17 (a) Burial (b) Date thereof 10-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Adath Israel Cemetery
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Washington Blvd. Baltimore, Md.

19 (a) 10/28/45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945, at 12:30 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Barbital poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 24, 1945 — M.
(b) Where did injury occur? Crandel Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury took phenobarbital

23. Signature Benedict Shatanelic M.D.
Medical Examiner.
Date signed 10-24-45

VS 151

633603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

633603 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution Calvert St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Liberty Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Saul Snyder
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1940
8. AGE: Years 5 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county and state)
10. Usual Occupation Wholesale Notions
11. Industry or business
FATHER 12. Name unknown
13. Birthplace Russia
MOTHER 14. Maiden Name unknown
15. Birthplace Russia
16 (a) Informant Lillian Snyder
(b) Address 3504 Liberty Heights Ave
17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10-28-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Jack Levin Inc
18 (a) Funeral director
(b) Address 1429 E. Balto St
19 (a) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1945 at 7:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1945 to Oct 25 1945; and that I last saw h[illegible] alive on Oct 25 1945

Immediate cause of death Coronary occlusion (2nd cause) — Duration 6 mos
Due to Intra-Scleritis Pedis Sin. — Duration 6 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan A. Krams M. D.
Address 1820 Eutaw Place Date signed Oct 26-45

VS 100

For H. H. McNally - by Howard L. Levin, M.D.

63360 about Nov 1 45 X 63360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 9: 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Johnstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 Branch Rd - (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Stankovich STANKOVICH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Louisa Petrosick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/1882

8. AGE: Years	Months	Days	If less than one day
63	6	3	hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Peter Stankovich
13. Birthplace Austria

MOTHER
14. Maiden Name Catherine
15. Birthplace Austria

16 (a) Informant Louis G. Stankovich
(b) Address 3592 Rt. 2 to Dut. Danville, Ky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director John O. Wiedefeld Sons
(b) Address 1901 Eastern Ave Baltimore, Md

OCT 28 1945

(a) (Registrar) (b) Registrar

VS. 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchogenic Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Maccini M.D. Medical Examiner.
Date signed 10-27-45

X

G33604

HB 14375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33604

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9 1
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Lancaster St. (If rural give location)
(e) Citizen of foreign country? ?? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schlupski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1856

8. AGE: Years 89 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Powell Schlupski
13. Birthplace Germany

MOTHER
14. Maiden Name Katie ??
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Benjamin Hill Road

18 (a) Funeral director John J. Fahey & Sons
(b) Address 138 E. Eight St.,

19 (a) 10/28/1945 (Date received by registrar) (b) Huntington Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1945 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 23, 1929 to Oct. 24, 1945 and that I last saw him alive on Oct. 24, 1945

Immediate cause of death Cardiac Arrest — Duration

Due to Severe arteriosclerosis — years
arteriosclerotic heart disease

Due to + peripheral gangrene

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Patonlli M. D.

Address B. C. H. Date signed 10-27-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

633605

JL - 96663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

633605

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2542 Francis St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Charles Koehlerschmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. ? 1945

8. AGE: Years	Months	Days	If less than one day
0	2 ?	20 ?	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edward Koehlerschmidt

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Elizabeth Stump

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-1945 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Balto Md

18 (a) Funeral director Maurice Book Byer

(b) Address 600 W. North Ave

28 1945 (b)

(Date rec'd by registrar)

Huntington Williams Reg. M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1945 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1945 to Oct. 25 1945, and that I last saw h im alive on Oct. 25 1945

Immediate cause of death Capillary Bronchitis — Duration 7 days

Due to

Due to

Other Conditions Diarrhea

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Walter M Tasen

Address BCH Date signed 10 27 45 M. D.

X TASEN

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1814 92 — 63306

BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 63306

CERTIFICATE OF DEATH — 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Jefferson St. (If no street address, give descriptive location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Handy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-03

8. AGE: Years	Months	Days	If less than one day
42 43	1	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER — 12. Name	Mat Carter
FATHER — 13. Birthplace	Va.
MOTHER — 14. Maiden Name	Louisa Jackson
MOTHER — 15. Birthplace	Va. Records.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory
Location Lyakins, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 2000 Brantley Ave

19 (a) 28 1945 (b) Registrar
Date received by registrar
Thurlow for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1945 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19, 1945 to Oct 25 1945 and that I last saw alive on Oct. 25 1945.

Immediate cause of death: Post Operative Pneumonia — Duration
Due to
Due to
Other Conditions Carcinoma of Stomach
(Include pregnancy within 3 months of death)
Date of operation Oct 25, 1945
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. A. Cooley
Address The Johns Hopkins Hosp. Date signed Oct 26 1945

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33607 BALTIMORE CITY HEALTH DEPARTMENT G33607
CERTIFICATE OF DEATH 83 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1273 Battery Ave.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1273 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella B. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Stephen B. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1857

8. AGE: Years 88 Months 1 Days 20 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Cannon
13. Birthplace Virginia

MOTHER
14. Maiden Name Ann Travers
15. Birthplace Maryland

16 (a) Informant Myrtle V. Cooper
(b) Address 1273 Battery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29. 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) (Date received by Registrar) (b) Huntington Willis, M.D.

OCT 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1945, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 45 to Oct 26 19 45 and that I last saw h alive on Oct 26 19 45

Immediate cause of death: Cerebral Thrombosis — Duration 5 hrs
Due to Arteriosclerosis
Due to Hypertension
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Muller M. D.
Address 225 S Clark St Date signed

X 10/27/45

633608 — BALTIMORE CITY HEALTH DEPARTMENT — 633595 Registered No.

CERTIFICATE OF DEATH 46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1946 W. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1946 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Isabella Graham Parkinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-0296

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1874

8. AGE: Years 71 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Sunderland Durham Co England (Town, county, and country)

10. Usual Occupation Woolen Operator

11. Industry or business

FATHER 12. Name George Parkinson
13. Birthplace England

MOTHER 14. Maiden Name Mary Graham
15. Birthplace England

16 (a) Informant Mrs. Mary Lewis
(b) Address 1946 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director Charles E. Deloeer
(b) Address Edmondson City Road

19 (a) (Date rec'd by registrar) Oct 28 1945 (b) Huntington Williams M.D. Registrar

VS 100 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1945 at 920A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1926 to 10/26 1945 and that I last saw h alive on 19

Immediate cause of death Carcinoma of Stomach — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 16-45

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Carlson M.D.
Address 2145 W Balto Date signed 10/27/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

633609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

633609 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Arnold (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Joseph Wiseman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Barthea L Wiseman
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1893

8. AGE: Years	Months	Days	If less than one day
52	10	13	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Joseph Wiseman
FATHER 13. Birthplace Balto Md
MOTHER 14. Maiden Name Sophia Wiseman
MOTHER 15. Birthplace Balto Md

16 (a) Informant Barthea L Wiseman
(b) Address Arnold Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/43 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Arnold Md

18 (a) Funeral director B L Hopkins
(b) Address Annapolis Md

19 (a) (b) (Signature of registrar)

OCT 28 1943

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1943 at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1943 to 10/28 1943; and that I last saw h~~im~~ alive on 10/27 1943.

Immediate cause of death Cachexia — Duration
Due to Generalized Metastatic Bronchiogenic Carcinoma
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Proved by biopsy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 10/28/43

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-14 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 30324 AND ENDING WITH 33609 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne
Re Rd

END OF REEL